DAKOTA PEDIATRIC CLINIC

Health Supervision: 1 Year

Patient Name:_____________________________________ **Date:** ___________________________

To provide good preventative health care for your child, we would like to you answer these questions. It will help us focus on areas of possible concern. Your responses will be respected and kept confidential. Please feel free to add information or comments.

1. What questions or concerns do you have today?

2. Have there been any unexpected stresses, or family changes since your last visit?
   List:

3. Do you use stairway gates? Y N

4. Are cleaning supplies and medicines stored up high or locked? Y N

5. Do you use a safety seat in the backseat every time you child rides in the car? Y N

6. Do you have smoke alarms in your house? Y N
   Do you have Carbon Monoxide alarms in your house? Y N

7. Do you use sunscreens on your child? Y N

8. What is your baby eating?

Fruit	Y	N	Formula	Y	N
Vegetables	Y	N	Milk	Y	N
Meat	Y	N	Whole milk	Y	N
Cereal/grains	Y	N	How many oz's each day?________		
Finger foods	Y	N			

9. Do you have a gun in your home? Y N
   Is the gun unloaded and locked up? Y N

10. Do you know CPR? Y N
    Do you know rescue maneuver for choking? Y N

11. Do you have any pets in your home? Y N
    What kind?

12. Do you have any support or help in caring for your child? Y N

OVER

13. Does anyone in your home smoke? Y N
Who?

14. Do you have concerns regarding conflict or violence in your home? Y N

15. Do you have any concerns regarding the use of alcohol or by anyone caring for your child? Y N

16. Does your child have problems falling asleep or sleeping all night? Y N

17. Does your child take a bottle to bed? Y N

18. Does your child eat hot dogs, peanuts, popcorn, raw carrots, hard candies? Y N

19. Has your child had any recent injuries? Y N

20. Do you any concerns about your child•s learning or behavior? Y N

21. Do you have any concerns about your child•s speech? Y N

22. Do you have any concerns about your child•s vision or hearing? Y N

23. Do you have any concerns about your child•s use of his arms, hands, or legs? Y N

Family History: Are you aware of any family members with the following history?
Please indicate which family members.

Y	N	Abuse/violence
Y	N	Allergy/asthma
Y	N	Attention deficit
Y	N	Arthritis
Y	N	Cancer
Y	N	Stroke
Y	N	Chemical dependency
Y	N	Diabetes
Y	N	Depression
Y	N	Drinking problem or alcoholism

Y	N	Drug addiction
Y	N	Elevated cholesterol
Y	N	High blood pressure
Y	N	Heart disease
Y	N	Kidney disease
Y	N	Learning problems
Y	N	Migraine headaches
Y	N	Obesity
Y	N	Seizures
Y	N	Other:

Parent/Guardian:______________________________