

# DAKOTA PEDIATRIC CLINIC



## Health Supervision: 2 Years

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. Does your child eat?
 

Fruit	Y	N	Milk	Y	N
Vegetables	Y	N	How many oz's each day?	_____	
Meats	Y	N	Juice	Y	N
Dairy	Y	N	How many oz's each day?	_____	
Cereals/Grains	Y	N			
  
4. In the car do you use a safety seat in the backseat every time? Y    N
  
5. Do you have smoke alarms in your house? Y    N  
Do you have carbon monoxide alarms in your house? Y    N
  
6. If you have a gun in your home is the gun unloaded? Y    N
  
7. Is the ammunition locked up and stored separately? Y    N
  
8. Do you use sunscreens on your child? Y    N
  
9. Has your child had any injuries since the last visit? Y    N
  
10. Does your child spend time with anyone that smokes? Y    N
  
11. Do you have concerns about your child's learning or behavior? Y    N
  
12. Do you have any concerns about your child's speech? Y    N
  
13. Do you have any concerns about your child's hearing or vision? Y    N
  
14. Do you have any concerns about your child's use of his arms, hands, or legs? Y    N

OVER

15. Have you begun to toilet train? Y N  
 Do you have questions about toilet training? Y N
16. Do you have any concerns regarding conflict or violence in your home? Y N
17. Do you have any concerns regarding the use of alcohol or drugs by anyone caring for your child? Y N
18. Does your child eat hot dogs, peanuts, popcorn, raw carrots, hard candies? Y N
19. Do you and your partner agree on how to set limits? Y N
20. Do you know CPR and the rescue maneuver for choking? Y N
21. Do you have the poison control phone number handy? Y N
22. Do you brush your child's teeth? Y N

Additional comments or questions:

**Family History:** Are you aware of any family members with the following history?

*Please indicate which family member.*

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: \_\_\_\_\_