DAKOTA PEDIATRIC CLINIC

Health Supervision: 4 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. Do you have any concerns about your child's hearing or vision? Y N

4. Has your child had any injuries since the last visit? Y N

5. In the car do you use a safety seat in the backseat every time? Y N

6. Are there any pets in your home? Y N
   Does you child know not to pet strange animals? Y N

7. Does your child know not to cross streets alone? Y N

8. Do you have smoke and carbon monoxide alarms in your house? Y N

9. If you have a gun in your home, is the gun unloaded? Y N

10. Is the ammunition locked up and stored separately? Y N

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

12. Does your child spend time with anyone that smoke? Y N

13. Do you have any concerns about your child's speech? Y N

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

15. Do you have any concerns about your child's learning or behavior? Y N

OVER

16. Do you have any concerns regarding conflict or violence that your child might be exposed to? Y N

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

18. Do you have the poison control phone number handy? Y N

20. Has your child been to a dentist this year? Y N

21. How much time does your child spend each day doing these activities?
Watching TV, playing video games, and/or using a computer? _________

22. Is your child attending pre-school? Y N
How often?
What does your teacher say about your child?

23. Does your child eat:

Fruits	rarely	sometimes	daily
Vegetables	rarely	sometimes	daily
Meats	rarely	sometimes	daily
Red meats	rarely	sometimes	daily
Milk	Y N	How many oz's each day? _________	

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

Y	**N**	Abuse/violence	**Y**	**N**	Drug addiction
Y	**N**	Allergy/asthma	**Y**	**N**	Elevated cholesterol
Y	**N**	Attention deficit	**Y**	**N**	High blood pressure
Y	**N**	Arthritis	**Y**	**N**	Heart disease
Y	**N**	Cancer	**Y**	**N**	Kidney disease
Y	**N**	Stroke	**Y**	**N**	Learning problems
Y	**N**	Chemical dependency	**Y**	**N**	Migraine headaches
Y	**N**	Diabetes	**Y**	**N**	Obesity
Y	**N**	Depression	**Y**	**N**	Seizures
Y	**N**	Drinking problem or alcoholism	**Y**	**N**	Other:

Parent/Guardian:_______________________________