

DAKOTA PEDIATRIC CLINIC



Health Supervision: 5 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 use a helmet when biking? Y N
4. Has your child attended preschool? Y N
How did he/she do at preschool?

5. Has your child seen the dentist in the past year? Y N

6. Does your child ride in a booster seat securely fastened in the backseat of the car? Y N

7. Does your child get along with other children well? Y N

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

9. Do you have any concerns about your child's learning, school readiness or behavior? Y N

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

11. What are the child care arrangements for your child before and after school?

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

13. Has your child ever been abused? Y N

OVER

14. Are there guns in your home? Y N
15. Are the guns unloaded and locked up? Y N
16. Is the ammunition stored separately? Y N
17. Do you have smoke alarms in your house? Y N
Do you have carbon monoxide alarms in your house? Y N
18. How much time does your child spend each day doing these activities:
Watching TV, playing video games, and/or using the computer? _____
19. Does your child eat:
- | | | | |
|------------|--------|-----------|------------------------------|
| Fruits | rarely | sometimes | daily |
| Vegetables | rarely | sometimes | daily |
| Meats | rarely | sometimes | daily |
| Dairy | 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	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: _____