

DAKOTA PEDIATRIC CLINIC



Health Supervision: 6 Months

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. Is your baby sleeping all night? Y N

4. Are you breastfeeding? Y N
Any problems?

5. Are you bottle-feeding? Y N
How many ounces does your baby drink per feeding? _____
How often are you feeding your baby? _____

6. Have you begun to childproof your home? Check ones done.

- | | |
|--|--|
| <input type="checkbox"/> Poisons/medications out of reach | <input type="checkbox"/> Cabinet latches |
| <input type="checkbox"/> Cords, outlet covers | <input type="checkbox"/> Stair gates |
| <input type="checkbox"/> Poison control number | <input type="checkbox"/> Irons, curling irons out of reach |
| <input type="checkbox"/> Water temp turned down below 120 deg. | |

7. Do you use sunscreens? Y N

8. Do you know infant CPR? Y N

OVER

- | | | | |
|--|------------|---|---|
| 9. Do you use rear-facing car seat?
Where is it located? | | Y | N |
| 10. Have you introduced solids? | | Y | N |
| 11. What is your baby eating? | Cereal | Y | N |
| | Fruits | Y | N |
| | Vegetables | Y | N |
| | Meats | Y | N |
| 12. Has your baby had any injuries this past 6 months? | | Y | N |
| 13. Does your child spend time with anyone that smokes?
Who? | | Y | N |
| 14. Does your child use a walker with wheels? | | Y | N |
| 15. Do you have any concerns about your child's vision or hearing? | | Y | N |

Additional questions or comments:

Parent/Guardian: _____