

**PARENTAL QUESTIONS
 FOR THE ADOLESCENT VISIT (II- 20)**

PATIENT NAME: _____

NAME OF PERSON FILLING OUT FORM:

RELATIONSHIP: _____

DATE: ____/____/____

NUTRITION

Is your child drinking milk? Yes No

If so, what type?
 whole 1% 2% skim soy rice other

How much milk does your child drink?
 < 8 ounces 8 to < 16 ounces 16 to 24 ounces 24 to 32 ounces >32 ounces

How much juice, GATORADE, SPORTS DRINKS AND SODA POP DOES YOUR CHILD DRINK?
 0 to 4 ounces 4 to 8 ounces 8 to 16 ounces >16 ounces

How much water does your child drink?
 < 8 ounces 8 to 16 ounces 16 to 24 ounces >24 ounces

WHAT TYPE OF WATER SOURCE DO YOU HAVE?
 city well bottled with fluoride bottled without fluoride

How many solid meals does your child eat in a day?
 1-2 2-3 3-4 4-5 5-6

How many snacks does your child eat in a day?
 0 1 1-2 2-3 >3

HAS YOUR CHILD COMPLETELY ELIMINATED ANY OF THE FOLLOWING FOOD GROUPS?
 meats vegetables fruits breads

ELIMINATION

STOOL
 Is your child continent of stool by day and night? Yes No

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING REGARDING HIS/HER BOWEL MOVEMENTS?
 pain fear holding large size or hard diarrhea blood in stool

FREQUENCY:
 every 3-4 days every other day every day 1-2 times per day > 3 times per day

URINE
 Is your child continent of urine during the day? Yes No
 Is your child continent of urine at night? Yes No
 Is your child having any problems with urination? Yes No

M.A.R. 2.2008 SIGNATURE OF PROVIDER: _____ DATE: ____/____/____

**PARENTAL QUESTIONS
 FOR THE ADOLESCENT VISIT (II- 20)**

PATIENT NAME: _____

DEVELOPMENT/RELATIONSHIPS

WHO DOES YOUR ADOLESCENT LIVE WITH MOST OF THE TIME? (Check all that apply.)

- | | | | |
|---|---|-----------------------------------|--|
| <input type="checkbox"/> Both parents in same household | <input type="checkbox"/> Other adult relative | <input type="checkbox"/> Guardian | <input type="checkbox"/> Sister(s)/ages |
| <input type="checkbox"/> Mother | <input type="checkbox"/> Stepmother | <input type="checkbox"/> Other | <input type="checkbox"/> Brother(s)/ages |
| <input type="checkbox"/> Father | <input type="checkbox"/> Stepfather | <input type="checkbox"/> Alone | |

PLEASE REVIEW THE TOPICS LISTED BELOW. Check (√) if you have a concern about your adolescent.

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Physical problems | <input type="checkbox"/> Change of appetite | <input type="checkbox"/> Amount of physical activity | <input type="checkbox"/> Choice of friends |
| <input type="checkbox"/> Smoking cigarettes/chewing tobacco | <input type="checkbox"/> Guns/weapons | <input type="checkbox"/> Drug use | <input type="checkbox"/> Sexual behavior |
| <input type="checkbox"/> Sexual transmitted diseases (STDs) | <input type="checkbox"/> Lying, stealing, or vandalism | <input type="checkbox"/> Physical development | <input type="checkbox"/> Sleep patterns |
| <input type="checkbox"/> Emotional development | <input type="checkbox"/> Self-image or self-worth | <input type="checkbox"/> Work or job | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> School grades/absences/dropout | <input type="checkbox"/> Alcohol use | <input type="checkbox"/> Unprotected sex | <input type="checkbox"/> Violence/gangs |
| <input type="checkbox"/> Relationships with parents and family | <input type="checkbox"/> Weight | <input type="checkbox"/> Diet/nutrition | <input type="checkbox"/> Sexual identity |
| <input type="checkbox"/> Excessive moodiness or rebellion | <input type="checkbox"/> Dating/parties | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Other: | | | |

What seems to be the greatest challenge for your teen?

What is it about your teen that makes you proud of him or her?

*Is there something on your mind that you would like to talk about today? Yes No
 What is it?

Can we share your answers to Question * with your teen? Yes No

**TUBERCULOSIS RISK
 ASSESSMENT QUESTIONNAIRE**

PATIENT NAME: _____

BIRTHDATE: ____/____/____

AGE: _____

DATE: ____/____/____

In order to determine whether or not a TB test is indicated for your child, we need you to answer the following questions. Because exposure risks can change, we will ask you to update this questionnaire at the 6, 12, 18, and 24 month well child visits and then annually until 21 years of age.

Respond to the following questions by checking the appropriate answer.

| | | | |
|---|------------------------------|-----------------------------|----------------------------------|
| Has a member of your family or a person who has contact with your child had tuberculosis disease? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Has a family member had a positive tuberculin skin (TB) test? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Was your child born in a country with a high rate of tuberculosis (places other than the United States, Canada, Australia, New Zealand, or Western European countries)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Has your child traveled (had contact with resident populations) to a high risk country for more than 1 week? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |

MAR 2.2008

SIGNATURE OF PROVIDER: _____ DATE: ____/____/____

Cholesterol Screening Questionnaire



PATIENT NAME: _____

BIRTHDATE: ___ / ___ / ___ AGE: _____ DATE: ___ / ___ / ___

Increasing evidence suggests that atherosclerosis (hardening of the arteries) and coronary heart disease (CHD) involve processes that begin in childhood and adolescence. Depending on family history, children at risk for hyperlipidemia (high fats in the blood) should be screened with a blood test (measuring either a cholesterol or LDL-C level depending on the risk factor) beginning at age two. Please complete this questionnaire to determine if your child has any of these risk factors. Screening can prevent complications by early recognition and treatment.

Respond to the following questions by circling the appropriate answer.

| | | | | |
|----|---|-----|----|---------|
| 1. | Does your child have a parent or grandparent who was diagnosed with coronary atherosclerosis (based on coronary angiography), including those who have had balloon angioplasty or coronary artery bypass surgery \leq 55 years of age ? | Yes | No | Unknown |
| 2. | Does your child have a parent or grandparent who has had a documented myocardial infarction (heart attack), angina pectoris (heart related chest pain), peripheral vascular disease (narrowing of the blood vessels within the body), cerebrovascular disease (narrowing of the blood vessels within the brain or having had a stroke), or sudden cardiac death \leq 55 years of age? | Yes | No | Unknown |
| 3. | Does your child have a parent with a cholesterol level \geq 240 mg/dl ? | Yes | No | Unknown |

Signature of Provider

_____/_____/_____
Date