



PATIENT NAME: _____

DATE: ____ / ____ / ____

Questions for 11-14 year visit

Please complete the following questions as they apply to your adolescent.

Who does your adolescent live with most of the time?

- parents (in the same household) mother father step-mother step-father
 sister(s) brother(s) guardian other: _____

Do you have any concerns about your adolescent (past or present) that you would like to talk about at today's visit? yes no

If yes, please explain? _____

Do you have any concerns about your adolescent and any of the following topics? yes no

- physical problems smoking cigarettes/chewing tobacco sexually related infections (SRIs) emotional development
 school grades/absences relationships with parents and family excessive moodiness or rebellion change in appetite
 guns/weapons lying, stealing, or vandalism self-image or self-worth alcohol use weight dating/parties
 amount of physical activities per day drug use physical development work or job unprotected sex
 diet/nutrition HIV/AIDS choice of friends sexual behavior sleep patterns pregnancy
 violence/gangs sexual identity depression

What seems to be the greatest challenge for your adolescent? _____

What is it about your adolescent that makes you most proud of him or her? _____

NUTRITION

Is your adolescent drinking milk? yes no

If yes, what type?

- whole 1% 2% skim soy rice

If yes, how much milk does your adolescent drink per day?

- < 8 oz 8 to 16 oz 16 to 24 oz 24 to 32 oz > 32 oz

How much juice, Gatorade, sports drinks, and soda pop does your adolescent drink per day?

- 0 to 4 oz 4 to 8 oz 8 to 16 oz > 16 oz

How much water does your adolescent drink per day?

- < 8 oz 8 to 16 oz 16 to 24 oz > 24 oz

Your adolescent has what type of water source?

- city well bottled with fluoride bottled without fluoride

How many meals does your adolescent eat per day?

- 1 to 2 2 to 3 3 to 4 > 4

How many snacks does your adolescent eat per day?

- none 1 1 to 2 >2

Has your adolescent eliminated any main food groups from his/her diet?

- meats vegetables fruits grains/breads

ELIMINATION

Is your adolescent having any problems with his/her bowel movements? yes no

If yes, please explain. _____

Is your adolescent having any problems with his/her urination? yes no

If yes, please explain. _____

SLEEP

Does your adolescent have a fairly consistent bedtime? yes no

How many hours does your adolescent sleep at night?

< 8 8 to 10 10 to 12 > 12

Does your adolescent have any problems with his/her sleep?

snoring restless sleep paused or startled breathing difficulty falling asleep night terrors
 poor sleep quality (being tired after sleeping) frequent nighttime awakenings nightmares teeth grinding
 other: _____

VISION

Do you have any concerns regarding your adolescent's vision? yes no

If yes, what? _____

HEARING

Do you have any concerns regarding your adolescent's hearing? yes no

If yes, what? _____

SOCIAL AND SCHOOL DEVELOPMENT

Does your adolescent get along with others at home? yes no

Does your adolescent get along with others at school? yes no

Is your adolescent adjusting well to school/home schooling? yes no

(Please circle the appropriate school setting in addition to answering the question.)

Is your adolescent doing well in school? yes no

Is your adolescent maintaining good school attendance? yes no n/a

Does your adolescent generally follow the rules at home? yes no

Does your adolescent generally follow the rules at school? yes no

Is your adolescent having disciplinary problems at school? yes no

Is your adolescent having problems with the law? yes no

PERSONAL HABITS

Does your adolescent use a computer in your home? yes no

If yes, where is the computer located?

the child's bedroom a secondary bedroom the office the family room

the living room the kitchen is portable

How much TV does your adolescent watch per day?

none < 30 minutes per day < 1 hour per day 1 to 2 hours per day > 2 hours per day

How much time does your adolescent spend playing video games per day?

none < 30 minutes < 1 hour 1 to 2 hours > 2 hours

What activities does your adolescent enjoy outside of school?

sports school clubs running bicycling exercise art

playing music listening to music using a computer videogames watching TV

watching movies reading spending time with friends

other: _____

SAFETY

Does your adolescent wear a seat belt when riding in a car? yes no

Does your adolescent wear a helmet or other protective gear for biking, skating, or water sports? yes no

Does your adolescent ride on an ATV? yes no

Is there a gun in your house? yes no

If yes, is it kept unloaded and locked with the ammunition locked separately from the gun? yes no

Do you have a pool? yes no

If yes, what type?

above ground without a fence in ground without a fence above ground with a fence around the pool

above ground with a fence around the yard in ground with a fence around the pool in ground with a fence around the yard

J.A.N. 27.2010 Signature of Provider _____ Date: ____ / ____ / ____



PATIENT NAME: _____ AGE: _____

PROVIDER: _____ DATE: ____/____/____

Tuberculosis Screening

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 and 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) like Mexico, South and Central America, Asia, India, and Eastern 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 |

M.A.R. 5.2010 Signature of Provider _____ Date: ____ / ____ / ____



PATIENT NAME: _____

PROVIDER: _____ DATE: ____/____/____

Cholesterol Screening

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 checking the appropriate answer.

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 **≤ 55 years of age**? Yes No Unknown

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 **≤ 55 years of age**? Yes No Unknown

Does your child have a parent with a cholesterol level **≥ 240**? Yes No Unknown

M.A.R. 5.2010 Signature of Provider _____ Date: ____/____/____