



PATIENT NAME: \_\_\_\_\_

DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Questions for 15-17 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 (SRI)     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 ad 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

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