11-15 YEAR OLD

Patient Name: _____

Person Filling Out Form: _____

Relationship to Patient: _____

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CONCERNS

yes	no	Do you have any questions or concerns today?

PERSONAL MEDICAL HISTORY

yes	no	Does your child take any medications (daily or as needed)? If so, please list: _____
yes	no	Has your child had any reactions to medications?
yes	no	Is your child currently taking any vitamins, supplements, "alternative medicines", or therapies?
yes	no	Are there any major changes or stresses in the family (moves, deaths, separation, etc.)?
yes	no	Has your child had any new illnesses, ER visits, hospitalizations, or surgeries since their last visit?
yes	no	Has a parent or household member ever had a problem with alcohol or drug use?
yes	no	Is there any new information to add to family medical history since the last well child visit?

FAMILY HISTORY

yes	no	unknown	Are there any major illnesses in the family? Which ones? _____
yes	no	unknown	Is there any family history of sudden cardiac death or arrhythmias?
yes	no	unknown	Does either biologic parent have elevated cholesterol or been prescribed a cholesterol medication?
yes	no	unknown	Has any family member died of heart problems or of sudden death **BEFORE AGE 50**?
yes	no	unknown	Has anyone in your family died for no apparent reason?
yes	no	unknown	Does anyone in your family have Marfan syndrome?

NUTRITION

yes	no	Does your child get at least 4-5 servings of fruits/vegetables each day?
yes	no	Does your child get at least 2-3 servings of calcium each day? (milk, cheese, yogurt or calcium supplements)?
yes	no	Does your child drink anything other than milk and water? If so, what? _____
yes	no	Does your child drink any caffeinated beverages, energy drinks, or protein drinks?
_____		How many times per week does your child eat fast food?
_____		How many times per week does your family eat meals together?

PREVENTIVE HEALTH

yes	no		Has your child seen a dentist in the past 6 months?
yes	no		Does your child brush their teeth twice daily?
yes	no		Does your child always wear a seat belt?
yes	no		Does your child get 8-12 hours of sleep each night?
yes	no		Is your child watching more than 2 hours of recreational screen time per day (TV, tablet, phone, movies, video games, etc.)?
yes	no		Does your child have a TV, phone, tablet, or computer in the bedroom?
yes	no		Does your child have outdoor time daily?
yes	no		Does your child always use a helmet when using a bike, a scooter, a skateboard, or skiing, etc.?
yes	no		Does your child live with anyone who smokes, vapes, or uses e-cigarettes or marijuana?
yes	no		Are there smoke alarms, fire extinguishers, and carbon monoxide alarms in your home?
yes	no		Have those alarms been checked in the past 12 months?
yes	no	N/A	If you own firearms, are they always locked up and ammunition stored separately?
yes	no		Has a family member or close contact had tuberculosis or had a positive test for tuberculosis?
yes	no		Was your child born in or traveled to a country for more than a week that may have a higher risk of tuberculosis and had contact with the resident population (countries outside the United States, Canada, Australia, New Zealand, or Western European countries)?

Please continue on the other side.

On average, how difficult was it for your family to meet expenses for basic needs like food, housing, and/or utilities in the past year? (Please circle one that most applies):

Never Seldom Some of the time Most of the time

REVIEW OF SYSTEMS *(CIRCLE ANY **CURRENT** CONCERNS YOU WOULD LIKE TO DISCUSS TODAY)*

yes	no	Headaches, fainting, dizziness, any loss of consciousness, or history of concussion
yes	no	Eyes (crossing, poor vision, etc.)
yes	no	Ears, hearing, nosebleeds, or snoring disrupting sleep
yes	no	Coughing, breathing, shortness of breath, wheezing, limited endurance, or chest pain
yes	no	Frequent stomachaches, vomiting, diarrhea, constipation, or blood in the stools
yes	no	Urination (change in frequency, or blood in the urine)
yes	no	Coordination or extremities (feet, legs, arms, hands)
yes	no	Problems with skin (moles or birthmarks that are changing, sores)

FEMALES:

_____ When was your first menstrual cycle (years old)?

_____ When was the first day of your most recent period?

yes no Menstrual irregularities, pain, or other concerns about your period?

ACADEMIC

What school does your child attend? _____ What grade level? _____

yes	no	Is your child involved in extracurricular activities? Which ones? _____
yes	no	Does your child receive any extra services? Please circle: tutoring, PT, OT, speech therapy, etc.
yes	no	Does your child have a 504 plan or IEP?
yes	no	Do you or the school have any concerns about your child's academics or behavior?

VISION/ HEARING

If your child has had a hearing or vision screen in the past 12 months, please indicate below:

Recent Hearing Screen Date _____ Recent Vision Screen Date _____

PHYSICAL ACTIVITY QUESTIONS

yes	no	Do you consider yourself physically active?
yes	no	Has a health care provider ever denied or restricted your participation in sports for any reason?
yes	no	Have you ever passed out or nearly passed out **WHILE** you are actually running or exercising?
yes	no	Have you ever passed out or nearly passed out **AFTER** you stopped running or exercising?
yes	no	Do you get discomfort, pain, or pressure in your chest during exercise?
yes	no	Does your heart skip beats or beat irregularly during exercise?
yes	no	Has a health care provider ever told you that you have: high blood pressure, heart murmur, heart infection, or Kawasaki's disease?
yes	no	Has a health care provider ever ordered a test for your heart (like an ECG or echocardiogram)?
yes	no	Do you have asthma, or has a doctor ever prescribed an inhaler to you?
yes	no	Do you get tired or short of breath more quickly than your friends during exercise?
yes	no	Have you experienced a muscle or bone injury that does not feel fully healed?
yes	no	Were you born without or are you missing a kidney, an eye, a testicle, spleen, or any other organ?
yes	no	Have you had infectious mononucleosis (mono) **WITHIN THE LAST MONTH**?
yes	no	Have you had a herpes or MRSA **skin** infection?
yes	no	Have you ever had a head injury or concussion? If so, when? _____
yes	no	Have you ever had a seizure?

PATIENT HEALTH QUESTIONNAIRE
PHQ-9 – Nine Symptom Checklist

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1. Over the *last 2 weeks*, how often have you been bothered by any of the following problems?

		Not at all	Several days	More than half the days	Nearly everyday
		0	1	2	3
a.	Little interest or pleasure in doing things	❑	❑	❑	❑
b.	Feeling down, depressed, or hopeless	❑	❑	❑	❑
c.	Trouble falling or staying asleep, or sleeping too much	❑	❑	❑	❑
d.	Feeling tired or having little energy	❑	❑	❑	❑
e.	Poor appetite or overeating	❑	❑	❑	❑
f.	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	❑	❑	❑	❑
g.	Trouble concentrating on things like school work, reading,or watching TV	❑	❑	❑	❑
h.	Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	❑	❑	❑	❑
i.	Thoughts that you would be better off dead or of hurting yourself in some way	❑	❑	❑	❑

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2. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
❑	❑	❑	❑

Total # Symptoms: _____ **Total Score:** _____