Reedsburg
AREA MEDICAL CENTER
Physicians Group

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Patient Questionnaire – 12-17 Year Well Child

Patient Name:_______________________________________ Date of Birth:___/___/___ Date:_________________

System Review/Screening	
Constitutional	Do you have problems with sleep pattern? (please circle) Yes No Do you have fevers, night sweats or weight changes? (please circle) Yes No
Eyes/Ears	Do you have vision or hearing concerns? (please circle) Yes No **Last vision screen was _______________** Do you wear corrective lenses? (please circle) Yes No
Cardiovascular/ Respiratory	Do you have cough or shortness of breath? (please circle) Yes No
Gastrointestinal	Do you have concerns about your diet? (please circle) Yes No Does patient have vomiting, diarrhea, constipation, or abdominal pain? (please circle) Yes No
Genitourinary	Do you have urinary problems? (please circle) Yes No

Please see reverse side

Musculoskeletal	Do you have pain of your bones, joints, or muscles? (please circle) Yes No
Skin	Do you have skin concerns? (please circle) Yes No
Neurological	Do you have headaches, visual changes, syncope, or seizures? (please circle) Yes No Do you have motor or sensory changes? (please circle) Yes No
TB Risk	Do you have a risk of tuberculosis exposure? (please circle) Low Risk High Risk
Caregiver Stress Screen	How much stress are you and your family under now? None Slight Moderate Severe Caregiver not present How stressful is caring for your child? None Slight Moderate Severe Caregiver not present

Adolescent History

Is there a family history of premature (before age 50) heart disease? (please circle)

Yes No

Do you have chest pain, palpitations, or dizziness with exercise? (please circle)

Yes No

Recent illnesses? (please circle)

Yes No

Recent injuries or accidents? (please circle)

Yes No

Adolescent History Cont.

Sexually active: (please circle)   Yes   No

If yes: Type of Contraception: _______________

Number of Partners: ___________

Females Only:

Age of menarche (start of period): ____________

Do you have any concerns about your menstrual period? (please circle)

Yes   No

History of smoking, vaping, drug use, or alcohol? (please circle)

Never   Past   Current   Social Use

Do you have any concerns about depression or anxiety? (please circle)

Yes   No

School: ______________________________

Grade Level: _________

Academic performance is: (please circle)   As   Bs   Cs   Ds   Failing

Extracurricular Activities (clubs/sports/outside hobbies): __________________________________

____

Do you have good relationships with family and friends? (please circle)

Yes   No