

## Patient Questionnaire – 12-17 Year Well Child

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Date: \_\_\_\_\_

<b>System Review/Screening</b>	
<b>Constitutional</b>	<p>Do you have problems with sleep pattern? (please circle)</p> <p style="text-align: center;">Yes      No</p> <p>Do you have fevers, night sweats or weight changes? (please circle)</p> <p style="text-align: center;">Yes      No</p>
<b>Eyes/Ears</b>	<p>Do you have vision or hearing concerns? (please circle)</p> <p style="text-align: center;">Yes      No</p> <p><b>Last vision screen was _____</b></p> <p>Do you wear corrective lenses? (please circle)</p> <p style="text-align: center;">Yes      No</p>
<b>Cardiovascular/ Respiratory</b>	<p>Do you have cough or shortness of breath? (please circle)</p> <p style="text-align: center;">Yes      No</p>
<b>Gastrointestinal</b>	<p>Do you have concerns about your diet? (please circle)</p> <p style="text-align: center;">Yes      No</p> <p>Does patient have vomiting, diarrhea, constipation, or abdominal pain? (please circle)</p> <p style="text-align: center;">Yes      No</p>
<b>Genitourinary</b>	<p>Do you have urinary problems? (please circle)</p> <p style="text-align: center;">Yes      No</p>

see reverse side

Please

<b>Musculoskeletal</b>	<p>Do you have pain of your bones, joints, or muscles? (please circle)</p> <p>Yes      No</p>
<b>Skin</b>	<p>Do you have skin concerns? (please circle)</p> <p>Yes      No</p>
<b>Neurological</b>	<p>Do you have headaches, visual changes, syncope, or seizures? (please circle)</p> <p>Yes      No</p> <p>Do you have motor or sensory changes? (please circle)</p> <p>Yes      No</p>
<b>TB Risk</b>	<p>Do you have a risk of tuberculosis exposure? (please circle)</p> <p>Low Risk      High Risk</p>
<b>Caregiver Stress Screen</b>	<p>How much stress are you and your family under now?</p> <p>None      Slight      Moderate      Severe      Caregiver not present</p> <p>How stressful is caring for your child?</p> <p>None      Slight      Moderate      Severe      Caregiver not present</p>
<b>Adolescent History</b>	
<p>Is there a family history of premature (before age 50) heart disease? (please circle)</p> <p>Yes      No</p> <p>Do you have chest pain, palpitations, or dizziness with exercise? (please circle)</p> <p>Yes      No</p> <p>Recent illnesses? (please circle)</p> <p>Yes      No</p> <p>Recent injuries or accidents? (please circle)</p> <p>Yes      No</p>	

### 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

### Depression History

Have you felt little interest or pleasure in doing things over the past 2 weeks? (please circle)

Not at all      Several days      More than half the days      Nearly every day

Have you felt down, depressed or hopeless over the past 2 weeks? (please circle)

Not at all      Several days      More than half the days      Nearly every day