



Teen Health Questionnaire

Office Use Only

VFC: [] MDD/DKC
 [] Native
 [] NO Insurance
 [] Not Eligible

INSURANCE Notes

Office Use Only

WT: _____ kg _____ lb
 Height: _____
 T: _____ P: _____ R: _____
 BP: _____ Pain: _____
 Vision: R: _____ L: _____

Note that "well child visits" are a form of preventative medicine, meant to catch any potential problems in a child's physical or developmental health. Each exam is tailored to the child's age, and may include necessary immunizations, vision, hearing, and developmental screenings. *If your child requires significant medical intervention or you request noteworthy management changes to existing chronic problems during this appointment, this may go above and beyond a preventative exam and may be coded and billed accordingly with your insurance, in which case your financial responsibility may also change.*

Your Name: _____ Birth Date: _____

Do you have any concerns about your health today? _____
 Are you on any medication? Yes / No. Which ones/dose? _____
 Do you have any allergies to medicines, foods, latex, etc.? Yes / No. Which ones? _____
 Have you had any difficulty with past immunizations? Yes / No. If yes, which ones? _____
 Is your mom or dad on medication for high cholesterol? Yes / No.
 Has your parent or grandparent had a stroke, heart attack, bypass surgery or stent, or died suddenly before age 50? Yes / No.
 Does anyone in the family have:
 Asthma? Yes / No. please circle: father/mother/sibling.
 Seasonal allergies? Yes / No. please circle: father/mother/sibling
 Food allergies? Yes / No. please circle: father/mother/sibling. To what? _____
 Have you had any surgeries? Yes / No. If yes, describe: _____
 Do you have any chronic medical problems? _____

Nutrition

Dairy use? Circle one: Whole milk 2% 1% Skim. How many total ounces of milk do you drink per day? _____
 If 8 oz milk, 8 oz yogurt, or 1½ oz cheese equal 1 serving of dairy, how many total servings of dairy do you consume each day? _____
 Circle your water supply source: City Bottled Well.
 How many ounces of juice, soda and other sugar-sweetened beverages do you consume each day? _____
 Do you eat a reasonable amount and variety of table foods? Yes / No.
 Are you on vitamins? Yes / No. Which ones? _____

Social

Any changes in your environment? (new home, family situation, dating, etc.) _____
 Who lives in the household with you? _____
 Does anyone in the family smoke? Yes / No. If yes, who? _____
 Which school do you attend? _____
 Grade Level: _____ Academic performance: _____
 Extracurricular activities/hobbies: _____
 How much vigorous physical exercise do you get each day? _____
 Do you work or volunteer? Yes / No. Where? _____
 Any pets in your home? Yes / No. Which ones? _____
 Does anyone in your family smoke? Yes / No. If yes, who? _____
 Are there firearms in your home? Yes / No.

Sleep and Elimination

Do you have any problems with: Sleep? Yes / No. Urinating? Yes / No. Stooling? Yes / No.

The following questions are asked to assess any risk factors that may interfere with participation in PE/sports and camp. Please answer them even if you do not participate.

Have you ever:

- Broken any bones? Yes / No. If yes, which one(s) and at what age? _____
- Passed out? Yes / No.
- Had a seizure or convulsion? Yes / No.
- Had a head injury / concussion? Yes / No.
- Had a very serious injury? Yes / No. Explain: _____
- Had numbness, tingling or weakness in the arms or legs after an injury? Yes / No.
- Been hospitalized overnight? Yes / No.
- Had wheezing, asthma, shortness of breath, or used an inhaler? Yes / No.
- Coughed with exercise? Yes / No.
- Complained of chest pain with exercise that interfered with activity? Yes / No.
- Had a racing heart or skipped heartbeats? Yes / No.
- Had severe, frequent headaches with exercise? Yes / No.
- Had severe, recurrent muscle cramps while exercising? Yes / No.
- Worried about your weight or carefully controlled what you eat? Yes / No.
- Tried to lose or gain weight? Yes/ No.
- Taken any medicines or supplements to try to improve your physical performance? Yes /No.
- Been denied participation in sports by a doctor for any reason? Yes / No.

FOR GIRLS ONLY:

- My periods started when I was _____ years old.
- Last period was: _____
- Any problems? _____

This form completed by: _____ Relationship to Child, if not Child: _____