Office Use Only	
VFC:	[ ] V02 -- MDD
	[ ] V03 – No Ins
	[ ] V04 -- Native
	[ ] V07 -- AVAP
INSURANCE:	
	Copay / Co-ins
	Statement Balance

Teen Health Questionnaire

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.*

Office Use Only

WT: ________________kg

WT: _______________lb

HT: ___________________

Temp: _______________

Resp: _______________

Pulse: _______________

Oxygen: _____________

BP: _________________

Vision: L_____________

R_____________

Child's Name: _____________________________________ Birth Date: ___________________

Who is your child's primary care physician? ____

Do you have any concerns about your child today? ____

Does your child have any allergies to medicines, foods, latex, etc.? Yes / No. Which ones?___________________________________

Has your child had any difficulty with past immunizations? Yes / No. If yes, which ones? ___________________________________

Has your child had any surgeries? Yes / No. If yes, describe: ____

Does your child have any chronic medical problems? ____

Is your child on any medicine/ vitamins? Yes / No. Which ones/dose? ____

Nutrition:

(Circle): Whole milk 2% 1% Skim Soy Other: ______| How many total ounces of **milk** does your child consume per day? ____

If 8 oz yogurt, or 1½ oz cheese equal 1 serving of dairy, how many total servings of dairy products does your child consume each day? ________________ # of meals / day____________________ # of snacks / day __________________

Does your child eat a reasonable amount and variety of table foods? Yes / No.

Does your child eat any of the following (please circle): Cereal | Vegetables | Fruits | Meat | Pasta | Fish

Circle your child's water supply source: City Bottled Well.

How many ounces of juice, soda and other sugar-sweetened beverages does your child consume each day? ____________________

Sleep and Elimination:

How many hours straight does your child sleep at night? ____________________

Does your child have any problems with: Sleep? Yes / No. Urinating? Yes / No. Stooling? Yes / No # of stools / day________

Education/Activities:

Which school does your child attend? ____

Grade Level: _________________ Academic performance: ____

Behavior: ____________________ Teacher feedback: ____

Is your child in any special education classes or programs? Please specify: ______________________________

Is your child in any therapies? Please specify: ____

Extracurricular activities: ____

Hobbies/ Interests: ____

How much vigorous physical exercise does your child get each day? ____________________________________

Social:

Any changes in your child's environment? (new home, pets, daycare, etc.)____

Is this child yours by: __ birth __ adoption __ marriage (stepchild) other ________________________________

Who lives in the household with the child? (Please list for all households if more than one) **Name, Relationship, Age** -

____

Marital status of Parents: __ married __ unmarried __ separated __ divorced __living together __ other: _______________________

Does this child live with you full-time? ____ Other? (Please describe)____

Who is the primary caretaker in the home? ______________________________

Does anyone in the household smoke (inside or outside)? Yes / No. If yes, who? __________________________________

Is Mom working? Yes / No. Full time / Part Time Occupation/place of work: _______________________________

Is Dad working? Yes / No. Full time / Part Time Occupation/place of work: _______________________________

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Do you have any pets in your home? Yes / No. Which kind/how many? ____
Any food allergies in your family? Yes / No. If yes, who and to what? ____
Any seasonal allergies or asthma in your family? Yes / No. If yes, who and to what? ____
Name of dentist: ____
Name of eye doctor: ____

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 your child is not participating.

Has your child 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 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.
Expressed concern about his/her weight? Yes / No.
Been denied participation in sports by a doctor for any reason? Yes / No.

Has anyone in your child's family died of heart problems or a sudden death before age 50? Yes / No. If yes, please list the relationship of the family member to the child: ____

FOR GIRLS ONLY:

My periods started when I was _________ years old.
Last period was: __________________________________
Any concerns? ____

This form completed by: ______________________________ **Relationship to Child:** ________________________ **Today's Date**___________________

Updated 11/16/16