Well Child Questionnaire for Children 11-15 Years Old

Patient name: _____ Birthdate: _____

Person completing form: _____ Today's date: _____

Please list any changes in the patient's home since the last visit. _____

_____

Please list any medical care received outside of our office since the last visit. _____

_____

Please list any changes to the patient's FAMILY history since the last visit. _____

_____

Please list all of the patient's current medications. _____

_____

Please list any known food or medication allergies. _____

Please circle or fill in where indicated.

1) Does the patient get at least 3 servings of calcium a day? (ex. milk, yogurt, cheese) Yes No

Please note that all dairy should be low fat or non fat.

2) Please list any multivitamins or supplements that the patient takes. _____

3) Has the patient had a fasting lipid panel (cholesterol) drawn previously? Yes No

4) Do you have any specific concerns regarding the patient's eating habits? Yes No

If yes, please describe. _____

5) Sleep is important for mental and physical wellbeing. Children should sleep 8-12 hours at night. Please list any specific sleep concerns you have. _____

6) What grade/school is the patient in? _____

7) Please list any assistance the patient is receiving. _____

_____

8) Please list any academic concerns. _____

_____

9) Please list any extracurricular activities. _____

_____

10) How many hours of physical activity a week does the patient get? _____

Please note that a minimum of 45 minutes 4 days a week is recommended.

11) Please list any concerns regarding the patient's social habits. _____

_____

_____

12) Are you concerned that the patient may have significant anxiety or depressive symptoms? Yes No

If yes, please describe. _____

_____

_____

13) Please list any concerns regarding the patient's pubertal development. For females, please note whether cycles have started and their frequency/duration/any related concerns. _____

_____

_____

14) The patient should continue routine dental exams/cleanings in addition to any other dental/orthodontic care.

Tuberculosis Risk Questionnaire

1) Was the patient born in or has the patient travelled to any of the following areas: Africa, Asia, Latin America, Eastern Europe, Russia? Yes No

2) Was the patient exposed to a household member who was born in or travelled to any of the above listed areas? Yes No

3) Was the patient exposed to anyone with known tuberculosis or anyone who had a positive skin or blood test for tuberculosis? Yes No

4) Does the patient spend time with someone who has been in a shelter, prison/jail, or someone who uses illegal drugs or has HIV? Yes No

5) Has the child ever had raw milk or any unpasteurized cheese? Yes No