ABC Pediatrics

13-18 year Pre-visit Questionnaire

Patient Name_____ Date_____

Academics: (Above average) (Average) (Below average)

Socialization: Interacts well with family? YES NO Interacts well with peers? YES NO

Bathes: Daily Every other day Appetite: Good Fair Poor

Diet: Balanced? ____ Eats fast food?____ Skips Meals?_____

Type of water (bottled/well/city): _____ # of hours sleeping at ONE time_____

Is there any secondhand smoke exposure in your home or car?_____

Current Dentist:_____ Current School:_____

Check all that apply:

- ☐ My child engages in behavior that supports a healthy lifestyle such as health diet and staying active
- ☐ My child has at least one responsible adult in their life who cares about them and who they can go to for help
- ☐ My child has at least one friend or one group of friends that they are comfortable with
- ☐ My child helps others individually or by working with a group in school, such as church or in the community
- ☐ My child is able to bounce back from life's disappointments
- ☐ My child has a sense of hopefulness and self confidence
- ☐ My child has become more independent and is making more of their own decisions as they become older
- ☐ My child is particularly good at doing certain things like math, cooking, theater, hunting: Describe_____

TB Screen	**Has a family member or contact been diagnosed with TB?**	**YES**	**NO**
	Was you child born in a country at high risk for TB?	**YES**	**NO**
	Has your child traveled to a country at high risk for TB?	**YES**	**NO**

Are there any other questions or concerns you would like to discuss?

_____

_____

For Office Use Only

Wt_____ Ht_____ BP_____ P_____ T_____ Vision_____Hearing_____

Please Turn Over ⇨

ADOLESCENT HEALTH HISTORY QUESTIONNAIRE (ages 12-17)

Please answer these questions privately. Give this form to your health care provider, who will be willing to discuss it with you. This information will not be shared with your parents unless we have your permission.

Age_____ Grade in school _____ Today's date _____

Who lives in your household? _____

Are you attending school? _____ What grades do you usually receive? _____

What are your future school or job plans? _____

Do you take any medicines (including birth control pills, diet pills, laxatives, steroids, vitamins)? _____

Females Only- Start date of last menstrual cycle_____ Any issues/concerns associated?..._____

_____

Have you been feeling sad about anything? . . . . . yes _____ no _____

Have alcohol or drugs caused a problem for you or someone you know? . . . . . yes _____ no _____

Have you used alcohol or drugs? . . . . . yes _____ no _____

How many times a week? _____

Do you use tobacco products (smoking, chewing)? . . . . . yes _____ no _____

Have you ever ridden in a car driven by someone (including yourself) who was "high" or drunk? _____

Have you considered suicide? . . . . . yes _____ no _____

Have you or anyone in your family been abused/raped/assaulted? . . . . . yes _____ no _____

Are you or any of your friends in a gang? . . . . . yes _____ no _____

Do you ever wonder about being gay? . . . . . yes _____ no _____

Have you ever had sexual relationships (gone all the way) with anyone? . . . . . yes _____ no _____

Do you want more information about birth control? . . . . . yes _____ no _____

Do you have any questions about AIDS or other STDs such as gonorrhea or chlamydia? Please specify:

_____

Are you having problems at home, school, or with friends? . . . . . yes _____ no _____

Are you pleased with your height and weight? . . . . . yes _____ no _____

Has anyone ever touched you in a way that felt uncomfortable to you? . . . . . yes _____ no _____

What do you consider to be methods of safe sex? _____

_____

Are there any guns in your home? . . . . . yes _____ no _____

Are you involved in sports? . . . . . yes _____ no _____

Is there anything else you would like to discuss during your visit? Please specify: _____

_____

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Signature Date