

COMPLETE BOTH SIDES OF THIS FORM, PLEASE

Patient's Name: _____

Date: _____

Completed by: _____

Relationship to patient: _____

HEALTH ASSESSMENT SCREENING QUESTIONNAIRE FOR 12-18 YEARS

(Adolescents do best when their parents and their doctors and nurses respect their autonomy and offer nonjudgmental support and advice. We demonstrate our respect for teenagers by examining them without their parents present and by promising them confidentiality. We want to assure you we will inform you if your adolescent poses a serious risk to himself or herself or to others. We will answer your questions as completely as possible without violating confidentiality. We encourage adolescents to discuss issues openly with their families. If you disagree with this policy, please let us know.)

Social/Environment

Home occupants (if multiple homes, list separately)

Pets _____ Please check if changes in family setting since last exam _____

Yes ___ No ___ Is your child exposed to tobacco products?

Yes ___ No ___ Does either parent smoke?

Yes ___ No ___ Does patient smoke?

Hearing:

Yes ___ No ___ Is there any family history of hearing impairment?

Yes ___ No ___ Any concern today regarding your child's hearing?

Vision

Yes ___ No ___ Does your child wear glasses or contact lenses? Date last vision exam: _____

Yes ___ No ___ Any family history of eye problems other than near or farsightedness?

Yes ___ No ___ Any concerns today regarding your child's vision?

Immunizations:

Yes ___ No ___ Has your child ever had a serious reaction to prior immunizations?

Yes ___ No ___ Has your child had Chicken Pox?

Tuberculosis screening: While the vast majority of children in the U.S. have little or no risk of becoming infected with tuberculosis, a few children may be at increased risk and should have a tuberculin skin test done. Please answer the following questions to help us determine your child's risk factors.

Yes ___ No ___ Is the child in close contact to a person sick with active TB disease?

Yes ___ No ___ Does the child have or is at risk to have HIV?

Yes ___ No ___ Was the child or the child's parents born outside of the United States?

Yes ___ No ___ Is the child exposed to a person in jail or a person who has been in jail in the past five years?

Yes ___ No ___ Is the child exposed to a person who has HIV, who is homeless or who lives in a nursing home or another group home?

PLEASE TURN PAGE OVER

- Yes ___ No ___ Is the child exposed to drug users or migrant farm workers?
Yes ___ No ___ Does the child have a health problem that lowers the immune system?
Yes ___ No ___ Does the child live in a community that has a high risk for TB?
Yes ___ No ___ Has the child traveled to or had a visitor from any foreign country since the last visit?
Yes ___ No ___ Does the child have any symptoms of TB (cough, fever, night sweats, loss of appetite, weight loss, or fatigue) or any abnormal chest x-ray?

Cholesterol screening may be recommended between the ages of 2-18 years if any of the following risk factors are present:

- Yes ___ No ___ Is there any history of heart disease, heart attack, or surgery such as angioplasty or bypass, or stroke in a parent or grandparent when that person was less than 55 years old?
Yes ___ No ___ Does either parent have a high blood cholesterol level?

Urinalysis: This is a routine screening for signs of infection, kidney disease and diabetes. Screening is done at all adolescent check-ups.

- Yes ___ No ___ Any concerns regarding your child's urine today?

Guns

- Yes ___ No ___ Do you have guns at your home?
Yes ___ No ___ If so, are they locked up and ammunition separately locked up?

Sports Related Questions: The following questions screen for risk factors for your child participating in sports:

- Yes ___ No ___ Has your child ever felt dizzy or passed out during exercise?
Yes ___ No ___ Has your child had a concussion or ever been unconscious?
Yes ___ No ___ Does your child cough frequently or get unusually short of breath with exercise?
Yes ___ No ___ Has your child ever had chest pain during or after exercise?
Yes ___ No ___ Is there a family history of cardiomyopathy, long Q-T syndrome or Marfan's Syndrome?
Yes ___ No ___ Is there a family history of sudden, unexplained death?
Yes ___ No ___ Has your child had any serious broken bones or sprains?

12-18 years
11/2007

Reviewed: _____