Name: _____ Date of birth: _____

Health Status Questionnaire – 11-14 years

Child lives with: mother father both parents other:_____
School: public private chartered home school
Grade: 5th 6th 7th 8th 9th
Performance: excellent good fair poor failing

Eating habits:
___ regular meals ___ snacks ___ grazes ___ skips meals ___ picky
___adequate fruits/veggies ___ mostly meat/carbs ___ fast food > 2x week
Milk/dairy products: ___ times per day ___ vegetarian

Activity: regular exercise active sports sedentary cannot tolerate exercise

Voiding habits: normal bedwetting accidents during day

Stool pattern: regular irregular hard constipation diarrhea

Sleep: 8-10 hours <8 hours difficulty falling asleep wakes at night

Safety:
Firearms/guns in home: Y N….Are the firearms/guns locked away: Y N
Insect protection: Y N Helmet use: Y N
Sunscreen: Y N ATV/motorcycle: Y N
Seat belt use: Y N Smoking status: Y N
Dental visits: Y N Passive smoke exposure: Y N
Aware of risks of drugs/alcohol: Y N

Do you limit your child to no more than 1-2 hrs of TV/computer/video games? Y N
Do you supervise your child's computer/internet activity? Y N

Tuberculosis (Tb) Screen Questions:
Has your child ever received BCG (a Tb vaccine given in some foreign countries)? Y N
Has there ever been tuberculosis/Tb in any household member? Y N
Was your child born or traveled for longer than 2 weeks to a country at high risk for tuberculosis (countries other than U.S., Canada, Australia, New Zealand or Western Europe)? Y N

(continue on back)

Review of Systems:

fatigue	y	n	stomachache	y	n	swollen glands	y	n
weight gain	y	n	heartburn	y	n	excessive bruising	y	n
weight loss	y	n	diarrhea	y	n	pale	y	n
blurred vision	y	n	constipation	y	n	genital discharge	y	n
eye irritation	y	n	nausea	y	n	irregular periods	y	n
snoring	y	n	vomiting	y	n	urination pain	y	n
stuffy nose	y	n	rash	y	n	scrotum swelling	y	n
earache	y	n	acne	y	n	genital pain	y	n
cough	y	n	eczema	y	n	food reaction	y	n
night cough	y	n	wart	y	n	hives	y	n
exercise coughy		n	knee pain	y	n	sinus congestion	y	n
mood swings	y	n	joint pain	y	n	passing out	y	n
headaches	y	n	limp	y	n	palpitation	y	n
change in gait	y	n	injury	y	n	dizziness	y	n
weakness	y	n	anxiety	y	n	chest pain	y	n

Do you have any concerns about your child? _____
_____

Depression screening (this section needs to be answered by the patient):
How often have you been bothered by each of the following symptoms during the past 2 weeks?
0 - not at all, 1 - several days, 2 - more than half the days, 3 - nearly every day
Little interest or pleasure in doing things: 0 1 2 3
Feeling down, depressed or hopeless: 0 1 2 3
Trouble falling or staying asleep, or sleeping too much: 0 1 2 3
Feeling tired or having little energy: 0 1 2 3
Poor appetite or overeating: 0 1 2 3
Feeling bad about self, that you are failure or have let self or family down: 0 1 2 3
Trouble concentrating on things, such as reading or watching TV: 0 1 2 3
Moving or speaking so slowly that other people notice or opposite-being so fidgety or restless that you have been moving around a lot more than usual: 0 1 2 3
Thoughts that you would be better off dead, or of hurting self in some way: 0 1 2 3

If your child has asthma, history of wheezing or uses inhalers/breathing treatments, please answer the following questions:
Cough/wheezing: 0-2 days/week >2 days/week daily throughout day
Nighttime cough: 0-1 night/month 2-3 nights/month 4 nights/month nightly
Use of rescue(albuterol) inhaler: <2days/week 2-4days/week daily several times/day
Interferes with normal activity: no limitations minor some severe
Oral steroid use: 0-1X/year 2-3X/year >3X/year
ER visits past year: 0 1 2 >3
Asthma hospitalizations past 2 years: 0 1 >2
Controller(steroid) inhaler: never prescribed not currently taking
taking every once in awhile taking regularly