



## 15-20 Year Health Maintenance Questionnaire

(parent to complete)

Patient Name \_\_\_\_\_

Who accompanied child today?  
(name and relationship to child) \_\_\_\_\_

Who does child live with? \_\_\_\_\_

Any Chronic health problems? \_\_\_\_\_

Concerns about the above health problems? \_\_\_\_\_

New or recent health concerns? \_\_\_\_\_

Any concerns with child's diet? \_\_\_\_\_

Does your child take vitamins? Yes No

Does your child or any household member

Does your child or any household member  
drink from a private well? Yes No  
(consider vacation homes, relative's or  
friend's homes, daycare or school)

Please list current medications: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Any allergies to medicine? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*If you do not understand any of these questions, please ask your nurse.*

**Tuberculosis Screening Questionnaire:**

Does your child have contact with adults with TB infection?

Yes No

Is child or parent are from region of world with high prevalence of TB?

Yes No

Is child frequently exposed to immunosuppressed persons, homeless people, nursing home residents, or migrant workers?

Yes No

Does either parent or other individual living in home work in a medically related field or have contact with institutionalized individuals or nursing home residents?

Yes No

**Cholesterol Risk Assessment Questionnaire:**

Parent or Grandparent with heart disease or stroke under the age of 55?

Yes No

Parent or Grandparent with elevated cholesterol >240?

Yes No

*If you do not understand any of these questions, please ask your nurse.*



## 15-20 Year Health Maintenance Questionnaire

(student to complete)

Patient Name \_\_\_\_\_

What School do you attend? \_\_\_\_\_

What grade are you in/entering? \_\_\_\_\_

How are your grades in school? (circle all that apply)      As   Bs   Cs   Ds   Fs

How often do you miss school? (circle one)      Rarely or never  
 1-2 time per semester  
 once a month or more

What activities/sports/clubs are you involved in? \_\_\_\_\_

What do you do in your free time? \_\_\_\_\_

How often do you exercise? (circle one)      Daily  
 3-4 times per week  
 1-2 times per week  
 less than once per week

How many hours do you sleep at night, on average? \_\_\_\_\_

Do you wear contacts or glasses? (circle one)      No    Contacts    Glasses

Do you wear your seat belt?      Yes    No

Are you concerned about your weight?      Yes    No

Are you doing anything to change your weight?      Yes    No

If so what? \_\_\_\_\_

Do your friends smoke, drink alcohol or use drugs?      Yes    No

***If you do not understand any of these questions, please ask your nurse.***

Have you ever tried smoking?	Yes	No
Have you tried illegal drugs?	Yes	No
Have you ever tried alcohol?	Yes	No
Have you ever talked to your parents/guardians about dating and sex?	Yes	No
Have you ever had sex?	Yes	No
Do you ever feel unsafe at home or at school?	Yes	No

Do you ever have thoughts about hurting yourself or that life isn't worth living?

	Yes	No
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Who do you usually talk to when you have a problem or concern?

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Have you ever fainted?	Yes	No
Have you ever fainted during exercise?	Yes	No
Have you had chest pain during exercise?	Yes	No
Has anyone in your family died suddenly?	Yes	No
Before age 35?	Yes	No
Before age 50?	Yes	No

If "yes" to either of the above, cause of death?

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Have you ever had a concussion, loss of consciousness, been knocked out or had a head injury?

	Yes	No
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If yes how many times?

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Have you ever had heat stroke or heat exhaustion?	Yes	No
Do you wheeze or cough during or after exercise?	Yes	No
Do you have, or have you ever had asthma?	Yes	No
Do you have any questions or concerns that you would like to discuss?	Yes	No

Females: At what age did you start your periods?

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Have you had any problems with your periods?	Yes	No
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***If you do not understand any of these questions, please ask your nurse.***