



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
drink from a private well?
(consider vacation homes, relative's or
friend's homes, daycare or school) Yes No

Please list current medications: _____

Any allergies to medicine? _____

Over Please

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 from a region of the world with a 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

Over Please

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

Who do you usually talk to when you have a problem or concern?

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, what was cause of death and relationship to patient?

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

Yes No

If yes how many times?

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?

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.