15-17 Year Pre-Visit Questionnaire

Instructions: Please have teen answer the questions below by circling or putting an X on the correct choice.

General Health		
1. Any concerns about your health today?	NO	YES
2. Do you receive health care from anyone besides a medical doctor (acupuncturist, herbalist, naturopath)?	NO	YES
Nutrition		
3. Eating 5 or more helpings of fruits/vegetables each day?	YES	NO
4. Are your breads, pastas, cereals mostly whole grain?	YES	NO
5. Do you eat or drink at least 2-3 servings of calcium rich food per day (beans, green leafy vegetables, milk, yogurt, cheese, calcium-fortified orange juice, soymilk or cereal)?	YES	NO
6. Do you eat more than 1 fast food meal per week?	NO	YES
7. Do you drink sugary drinks (soda, juice, energy drinks)?	NO	YES
8. Do you eat meals together as a family?	YES	NO
9. Do you have any concerns or questions about the size or shape of your body?	NO	YES
10. In the past year have you tried to control your weight by vomiting, taking diet pills or laxatives, or starving yourself?	NO	YES
Oral Health		
11. Do you brush your teeth at least twice a day?	YES	NO
12. Do you floss your teeth at least once a day?	YES	NO
13. Have you been to the dentist in the last year?	YES	NO
Activity		
14. Do you participate in any physical activities such as walking, skateboarding, dancing, swimming, or playing basketball at least 4 days per week?	YES	NO
15. Do you play competitive sports?	NO	YES
a. If yes, is there any family history of heart problems or sudden death?	NO	YES
16. Do you watch TV, play video games, or spend time on the computer more than 2 hours per day (not including computer time for homework)?	NO	YES
a. Do you have a TV, video game machine, or computer in your room?	NO	YES
School		
17. Are you having problems in school or work?	NO	YES
18. Grades worse than last year?	NO	YES
19. Trouble concentrating?	NO	YES
20. Fighting?	NO	YES
21. Homework problems?	NO	YES
22. Suspension in the last year?	NO	YES
23. Missing school or work?	NO	YES
Injury Prevention		
24. Do you always wear a seat belt when you are in a car?	YES	NO
25. Do you wear a helmet when you play team sports, in-line skate, skateboard, bicycle, ski, snowboard, or ride a motorcycle, ATV, minibike, or snowmobile?	YES	NO

26. Do you ever carry a gun?	NO	YES
27. Is there a gun in your home?	NO	YES
28. Have you started to learn how to drive or do you drive?	NO	YES
a. Use a cellphone or headphones while driving?	NO	YES
b. Do you text while driving?	NO	YES

Tuberculosis

29. Has a family member or contact had tuberculosis disease?	NO	YES
30. Has a family member had a positive TB skin test (PPD)?	NO	YES
31. Was your child born in a high-risk country (countries other than the U.S., Canada, Australia, or Western Europe)?	NO	YES
32. Has your child traveled to a high-risk country for more than a week?	NO	YES

Emotional Wellbeing

33. Do you worry a lot or feel overly stressed out?	NO	YES
34. When you are angry, do you do violent things?	NO	YES
35. Do you find yourself continuing to remember or think about an unpleasant experience that happened in the past?	NO	YES
36. During the past few weeks have you often felt sad or down, had difficulty sleeping, frequently felt irritable, or felt like you have nothing to look forward to?	NO	YES
37. Have you ever seriously thought about killing yourself, made a plan, or actually tried to kill yourself?	NO	YES
38. Is there someone at home, school, or work that has made you feel afraid, threatened you, or hurt you?	NO	YES
39. Even with usual ups and downs, do you enjoy life?	YES	NO
40. Do you get along with your family?	YES	NO
41. Do you follow your family's rules?	YES	NO

Review of Systems: *Any **Concerns** about...*

42. Eating habits, weight loss, or lack of energy?	NO	YES
43. Sleep problems, including excessive snoring?	NO	YES
44. Eye redness, excessive tearing or discharge?	NO	YES
45. Recurrent ear, sinus or throat infections, nosebleeds?	NO	YES
46. Chest pain, shortness of breath, or irregular heartbeat?	NO	YES
47. Frequent colds, cough, wheezing, recurrent lung infections?	NO	YES
48. Abdominal pain, vomiting, diarrhea, constipation?	NO	YES
49. Kidney or bladder problems, infections, blood in the urine?	NO	YES
50. Birthmarks, skin rashes, itching, nail or hair problems?	NO	YES
51. Joint pain, stiffness, swelling, muscle pain or weakness?	NO	YES
52. Headaches, dizziness, tics, weakness, seizures?	NO	YES
53. Mood changes, sadness, nervous problems?	NO	YES
54. Excessive thirst or hunger, increased urination?	NO	YES
55. Paleness, anemia, easy bruising, swollen glands?	NO	YES
56. Puberty?	NO	YES

For females:

57. Have you gotten your period?	YES	NO
58. Problems or questions about menstruation?	NO	YES
59. Do you get your periods monthly (21-35 days apart)?	YES	NO
60. When was your last period?		