15-17 Year Pre-Visit Questionnaire

Instructions: *Please answer the questions below by circling or putting an X on the correct choice. These questions help us assess your health, development, and safety.*

General Health

1	Do you have any concerns about your health today?	NO	YES
2	Does your child receive health care from anyone besides a medical doctor, nurse practitioner or physician's assistant (acupuncturist, chiropractor, naturopath)?	NO	YES

Feeding/Nutrition

3	Do you eat 5 or more helpings of fruits/vegetables each day?	YES	NO
4	When you eat grains (cereal, bread, pasta, crackers, waffles, rice, etc.), are they mostly whole grains?	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)?	YES	NO
6	Do you eat junk foods (chips, cookies, crackers, candy) and/or fast foods more than 2-3 times per week?	NO	YES
7	Do you snack more than 2 times a day on foods other than fruits and vegetables?	NO	YES
8	Do you drink soda, juice or other sweetened drinks more than once or twice per week?	NO	YES
9	Do you eat meals together as a family?	YES	NO
10	Do you have any concerns or questions about the size or shape of your body?	NO	YES
11	In the past year have you tried to control your weight by vomiting, taking diet pills or laxatives, or starving yourself?	NO	YES
12	Are you taking any vitamins or supplements?	NO	YES

Oral Health

13	Do you see a dentist at least twice a year?	YES	NO

Activity

14	Do you play any competitive sports?	NO	YES
15	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 screen time for homework)?	NO	YES
	a. Do you have screen time in your bedroom (TV, video games, computer, tablet, smart phone)?	NO	YES

17 Are you active (exercising/heart rate elevated) for at least 1 hour every day?	YES	NO
18 Do you have a hard falling asleep or staying asleep at night?	NO	YES
19 Are you sleeping 8-10 hours at night?	YES	NO
20 Do you work?	NO	YES
a. If yes, where do you work?		
b. If yes, how many hours per week?		

School

21 Are you having problems in school or work?	NO	YES
22 Are your grades worse than last year?	NO	YES
23 Do you have trouble concentrating?	NO	YES
24 Have you been getting into fights?	NO	YES
25 Do you have problems doing your homework?	NO	YES
26 Have you been suspended in the past year?	NO	YES
27 Have you missed more than a few days of school in the last year?	NO	YES
28 Do you have an IEP or other learning plan?	NO	YES

Injury Prevention

29 Do you always wear a seat belt when you are in a car?	YES	NO	
30 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	
31 Do you ever carry a gun?	NO	YES	
32 Is there a gun in the home?	NO	YES	
a. If yes, is it locked in a safe with the ammunition stored separately?	YES	NO	DOESN'T APPLY
33 Have you started to learn how to drive or do you drive?	NO	YES	
a. Have you ever used a cellphone, texted, or used headphones while you were driving?	NO	YES	

Tuberculosis

34 Has a family member or contact had tuberculosis disease (TB)?	NO	YES
35 Has a family member ever had a positive TB skin test (PPD)?	NO	YES
36 Were you born in a high-risk country (countries other than the U.S., Canada, Australia, or Western Europe)?	NO	YES
37 Have you traveled to a high-risk country for more than a month?	NO	YES

Emotional Wellbeing

38 Do you feel stressed out, anxious, moody or overly worried?	NO	YES
39 Does your nervousness/worrying make it hard for you to do well in school/at home/or with your other activities?	NO	YES
40 When you are angry, do you do violent things?	NO	YES
41 Have you ever seriously thought about hurting or killing yourself or someone else?	NO	YES
42 Do you get along with your family and follow their rules?	YES	NO
43 Have you experienced bullying or harassment on social media (Facebook, Snapchat, Intagram, etc?)	NO	YES
44 Is there someone you are dating or a person at home or at school that is hurting you?	NO	YES

Review of Systems

45 Do you have any concerns about eating habits, weight loss, or lack of energy?	NO	YES
46 Do you have any sleep problems, including a lot of snoring?	NO	YES
47 Do you have any concerns about your eyes or your vision?	NO	YES
48 Do you have concerns about recurrent ear, sinus or throat infections, nosebleeds?	NO	YES
49 Do you have chest pain, shortness of breath, or irregular heartbeat?	NO	YES
50 Do you have concerns about frequent colds, cough, wheezing, recurrent lung infections?	NO	YES
51 Do you have concerns about abdominal (stomach) pain, vomiting, diarrhea, constipation?	NO	YES
52 Do you have concerns about kidney or bladder problems, infections, or blood in your urine (pee)?	NO	YES
53 Do you have concerns about your skin, hair, or nails?	NO	YES
54 Do you have concerns about joint pain, stiffness, swelling, muscle pain or weakness?	NO	YES
55 Do you have concerns about recurrent headaches, dizziness, tics, weakness, seizures?	NO	YES

56 Have you had excessive thirst or increased urination?	NO	YES
57 Have you had paleness, anemia, easy bruising, or swollen glands?	NO	YES
58 Do you have concerns about puberty?	NO	YES

For biological females:

59 Have you gotten your period?	YES	NO
60 Do you have any problems or questions about menstruation (getting your period)?	NO	YES
61 Do you get your periods every 21-42 days?	YES	NO
62 When was your last period?		