10-11 Year Visit Questionnaire

Patient's Last Name: _____ **First Name:** _____ **Birthdate:**_____ **Today's Date:**_____

	CIRCLE		*(If yes, explain below)
General:			
Do you have any specific concerns for today's visit?	No	Yes*	
Is your child taking any prescription medications?	No	Yes*	
Are your child's vaccines covered by your insurance plan?	No	Yes	
Is your child seeing a specialist for any ongoing medical problem(s)?	No	Yes*	
Has your child been seen in a hospital ER or treatment center since the last visit here?	No	Yes*	
Does your child have any ongoing medical problems or diagnosis? (If yes, please list on bottom.)	No	Yes*	
Family Medical:			
Do the parents have any significant medical issues that we should be aware of?	No	Yes*	
Have there been any other significant family medical issues recently?	No	Yes*	
Social:			
Are the biological parents married?	No	Yes	
Are there any new stressful events, losses, deaths, job changes, or social issues of concern recently?	No	Yes*	
Are there any smokers in the household? (If yes, please indicate who)	No	Yes*	
Do you have any concerns regarding domestic abuse or child abuse in your household?	No	Yes*	
Symptom Review:			
Has your child had any fever (over 100.4), runny nose or significant cough in the last 3 days?	No	Yes*	
Do you have any concerns regarding your child's sleep habits?	No	Yes*	
Do you have any concerns regarding your child's behavior?	No	Yes*	
Does your child wear glasses or contacts? If yes, Please circle: Glasses Contacts	No	Yes*	
Do you have any concerns regarding your child's hearing?	No	Yes*	
Is the child having any significant breathing problems that you are concerned about?	No	Yes*	
Has your child had episodes of vomiting recently?	No	Yes*	
Does your child complain of abdominal pain that is frequently recurring or persistent ?	No	Yes*	
Do you have any concerns regarding your child's stooling habits?	No	Yes*	
Do you have any concerns regarding your child's voiding/urinary habits?	No	Yes*	
Does your child complain of joint, bone or muscle pain that is frequently recurring or persistent ?	No	Yes*	
Does your child complain of headaches that are frequently recurring or persistent ?	No	Yes*	
Does your child have any unusual rashes that you are concerned about?	No	Yes*	

*Explain 'YES" Answers: _____

_____

Patient Last Name:_____ **First Name:** _____

Birthdate:_____ **Today's Date:** _____

SCREENING QUESTIONNAIRE FOR CARDIAC DISEASES IN CHILDREN AND YOUNG ADULTS

(PLEASE HAVE PARENT ASSIST WHEN ANSWERING THESE QUESTIONS)

There are several very rare conditions that can lead to serious cardiac problems or cardiac arrest that may occur during sports or exercise programs in children or young adults. Some of these conditions cannot be foreseen or predicted by any pre-participation screening questionnaire or even a pre-participation physical exam because there may be no clues from the family history, prior symptoms, or physical exam. There are some key symptoms and family history clues that may help to direct us to obtain more specific and comprehensive cardiac studies in an effort to identify individuals who have a serious cardiac condition. Because these conditons are so rare, it is not advisable to obtain comprehensive cardiac testing on every child or young adult beginning a sport or exercise program. Accordingly, please answer the following questions and return this form back to the nurse or physician.

	PLEASE CIRCLE THE ANSWER	
Have you ever passed out during or right after exercise?	YES	NO
Do you become dizzy during or right after exercise on an ongoing basis?	YES	NO
Do you have chest pain during or right after exercise on an ongoing basis?	YES	NO
Do you hear your heart racing in an irregular manner or skipping beats on more than one occasion when not engaged in heavy exercise?	YES	NO
Do you get much more tired during exercise than others your own age and size?	YES	NO
Has any family member ever suffered a heart attack or sudden death during exercise at an early age(under 50 years)?	YES	NO
Do you have a family member diagnosed under age 50 with a cardiac rhythm disturbance(arrythmia) or an electrocardiogram abnormality?	YES	NO
Do you have a family member diagnosed under age 50 with an abnormality of the heart's muscle(cardiomyopathy)?	YES	NO
Do you have a family member with these specific conditions: prolonged QT syndrome or Marfan's syndrome?	YES	NO
Have you been told that you have a heart murmur?	YES	NO

Details:

_____

Patient Last Name: _____ First Name: _____

Birthdate: _____ Today's Date: _____

PEDIATRIC WELLNESS QUESTIONAIRE AND ACTION PLAN (AGES 2-21 YEARS)

Nutrition

Please estimate the average number of total servings per day of both fruits and vegetables:
(1 serving is about 1/2 cup)

☐1 or less ☐2 ☐3 ☐4 ☐5 or more

Goal: 5 or more servings per day fruits and vegetables is recommended.

Please estimate the average number of total servings per day of water:

☐1 or less ☐2 ☐3 ☐4 or more

Goal: 4 or more servings per day of water is recommended.

Please estimate the average number of total servings of the following:

Milk (either cow's milk or other milk substitute): ☐none ☐1 ☐2 ☐3 or more

Other dairy (i.e. cheese, yogurt, ice cream): ☐none ☐1 ☐2 ☐3 or more

Please indicate the type of milk: ☐FAT FREE ☐1% ☐2% ☐WHOLE ☐OTHER_____

Goal: 3 or more total calcium containing food/beverage servings per day is recommended for adequate daily calcium intake. If you are not meeting this requirement, then please discuss with your provider the role of calcium supplements.

Does the patient take a daily multiple vitamin? ☐YES ☐ NO

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Physical Activity

Please estimate the total number of average time per day spent physically active– please include any sports, gym class in school, running around, biking, active play time, or any non-sedentary activity. Averaging implies that if two hours of activity one day and none the next day, then that would average to 1 hr per day:

Approx time per day in hours: ☐Less than 1 hour ☐1 hour or more

Goal: An average of 1 hour or more per day of physical activity is recommended.

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Screen Time

Please estimate the average amount of time per day spent watching TV, using recreational computer, or video gaming (do not include computer time used for school or work based homework):

Approx time per day in hours: ☐Less than 2 hours ☐2 hours or more

Goal: Total recreational screen time should average less than 2 hours per day.

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Hypertension Counseling

Hypertension, also known as high blood pressure, is very common among adults, but can also occur in children and teenagers. Healthy lifestyles begun during childhood can help lower the risk of hypertension in adulthood, including (1) maintaining a healthy weight, (2) regular aerobic type exercise sustained all year long, (3) modest salt intake, and (4) learning to manage stress in an effective and positive manner. Another important component is regular yearly physical exams to monitor and check blood pressure beginning in childhood. Family history is also an important risk factor. Lastly, hypertension often has no symptoms and may go undetected without regular exams.