



Health Maintenance Questionnaire

CONFIDENTIAL --- DO NOT COPY

ADOLESCENT
AGE 11 and OVER

PATIENT NAME _____ BIRTH DATE ____/____/____ AGE TODAY ____ GRADE ____

PARENTS _____ SCHOOL _____ TODAY'S DATE ____/____/____

REASON FOR THIS CHECK UP: 7th Grade School Sports Camp Work Routine check-up Other:

PATIENT CONCERNS

What questions or concerns do you have? →

Please circle any body areas that concern you:

Head	Heart	Bones	Hormones
Eyes	Lungs	Joints	Blood
Ears	Intestines	Muscles	Glands
Nose	Kidneys	Brain	Immunity
Mouth	Genitals	Nerves	
Throat	Skin	Mental Health	

Answer the questions below by checking YES or NO.
Explain "YES" answers in the space below.

HISTORY

Yes No

PHYSICIAN'S COMMENTS

Do you have a recurrent medical or psychological problem?		
Have you ever had: a serious illness or stayed overnight in a hospital?		
an operation?		
List medications taken routinely or only as needed: (Include birth control pills, vitamins/supplements/herbs, nebulizers, inhalers, nose sprays, eye/ear drops, skin creams, etc.) <input type="checkbox"/> No medications		
Do you have allergies: (circle) hay fever, asthma, hives, foods, medicine _____		
Are there any illnesses that run in your family? Any high cholesterol?		
Have you seen a doctor outside of this clinic for any reason?		
Do you need any immunizations (such as Tetanus) as far as you know?		
How many servings a day do you eat: Juice ____ Pop ____ Fruit ____ Veg ____ Meat ____ Milk ____ Milk products ____		
Do you usually drink water that is NOT fluoridated? <input type="checkbox"/> Don't know		
Has it been more than 1 year since your last dental check-up?		
Do you have concerns about your vision or hearing?		
Do you have problems with acne/pimples?		
Males: Have your testicles or scrotum ever felt abnormal to you?		
Females: When was your last period? _____ <input type="checkbox"/> Haven't had it yet.		

See *Student Preparticipation Medical History* form for information regarding neurologic and cardio-respiratory status/risk factors, history of injuries, etc.

- Prescribed fluoride vitamins.
- Recommended dental check up.
- Recommended monthly testicular exam.
- If menstruating, see female adolescent questionnaire.

PLEASE TURN THE PAGE OVER AND ANSWER MORE QUESTIONS!!

Explain questions answered with "yes." _____
Give approximate dates. _____

ASSESSMENT

- See Physical Exam Summary and other side of this form for more information.
- _____
- _____
- _____
- _____
- _____

PLAN

- Anticipatory Handouts given. Discussed hazards of smoking
- _____
- _____
- _____
- _____
- _____

PHYSICIAN'S SIGNATURE: _____ DATE: _____

ADOLESCENT (age 11 and over)

Who do you live with? _____ Do you get along with your parents or custodians? _____

What activities are you involved in? _____

What do you like to do for fun? _____

Note if there are any specific learning or behavior problems at school: _____

Do you have trouble making or keeping friends? _____ Do you get into fights often? _____

What kind of grades do you get? Excellent Good Fair Poor Failing

HEALTH, SAFETY and LIFESTYLE		Yes	No	PHYSICIAN'S COMMENTS <input type="checkbox"/> Discussed the hazards of smoking, inhalants, alcohol and drugs.
Are you around friends who smoke or use tobacco?				
Do you smoke or use tobacco?				
Have any of your friends sniffed glue or breathed inhalants?				
Have you ever sniffed glue or breathed inhalants?				
Do your friends drink alcohol?				
Have you ever drunk alcohol?				
Do you have any friends that use drugs?				
Have you ever done drugs?				
Does anyone in your family or household smoke, drink or use drugs?				
Are there any guns in your home?				
Do you always wear a seat belt?				
Do you wear a helmet when you ride a bike? <input type="checkbox"/> I don't ride one.				
Do you know how to swim?				
Do you have smoke detectors and a fire escape plan at your house?				
Which do you think your body is? <input type="checkbox"/> Just right <input type="checkbox"/> Too thin <input type="checkbox"/> Too fat				
Has your weight changed this past year? <input type="checkbox"/> No change <input type="checkbox"/> Gained ___ pounds <input type="checkbox"/> Lost ___ pounds				
Have you ever been abused verbally, physically or sexually?				
Have you ever had sex? <input type="checkbox"/> I'd rather not answer that question.				
MOOD SURVEY				
This past year, how often have you been bothered by:	Not at all	Somewhat	Very Much	
Worrying a lot?	1	2	3	
Feeling nervous or tense?	1	2	3	
Getting your feelings hurt?	1	2	3	
Feeling too tired to do things?	1	2	3	
Feeling like crying?	1	2	3	
Having trouble going to sleep or staying asleep?	1	2	3	
Feeling unhappy, sad or depressed?	1	2	3	
Feeling hopeless about the future?	1	2	3	
Feeling like life isn't worth living?	1	2	3	
Feeling like hurting yourself?	1	2	3	
Are you HAPPY or SAD most of the time? (circle one)				
TUBERCULOSIS (TB) RISK		Yes	No	
Have you been around anyone with contagious TB or a positive PPD test?				
Have you had contact with people from Asia, Middle East, Africa or Latin America?				
Is anyone living in your house infected with HIV?				
Have you been exposed to any of the following people: homeless, nursing home residents, institutionalized people, jail/prison inmates, users of illicit drugs, migrant farm workers.				
Do you have cancer, diabetes, kidney failure, HIV, poor nutrition or an immunosuppressive condition?				

TB Risk: High
 Low

Thank you for helping us by answering the above questions!!

Please put this paper in the box hanging outside the door so that we know you are finished!

	ASSESSMENT	ADVICE GIVEN	DIET
H	LR IR HR/U _____	_____	FAT _____
E	LR IR HR/U _____	_____	IRON _____
A	LR IR HR/U _____	_____	CALCIUM _____
D	LR IR HR/U _____	_____	CALORIC BALANCE _____
S	LR IR HR/U _____	_____	
S/D	LR IR HR/U _____	_____	
SAFETY	LR IR HR/U _____	_____	



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STUDENT PREPARTICIPATION MEDICAL HISTORY

STUDENT NAME _____ MALE FEMALE
BIRTH DATE ____/____/____ **GRADE** ____ **AGE** ____ **SCHOOL** _____
ACTIVITY _____

STUDENT MEDICAL QUESTIONNAIRE

***Circle questions you don't know the answers to. Explain "Yes" answers below.**

<p>1. Has there been a medical illness or injury since the last check-up or sports physical? Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>2. Has the student ever: been hospitalized overnight? <input type="checkbox"/> <input type="checkbox"/> had surgery? <input type="checkbox"/> <input type="checkbox"/></p> <p>3. Is the student currently using: prescription or over-the-counter medications/pills? <input type="checkbox"/> <input type="checkbox"/> an inhaler? <input type="checkbox"/> <input type="checkbox"/> supplements or vitamins to gain or lose weight? <input type="checkbox"/> <input type="checkbox"/> or to improve athletic performance? <input type="checkbox"/> <input type="checkbox"/></p> <p>4. Does the student: lose weight regularly to meet weight requirements for a sport? <input type="checkbox"/> <input type="checkbox"/> want to weigh more or less than at present? <input type="checkbox"/> <input type="checkbox"/></p> <p>5. Has the student had any problem with their eyes or vision? <input type="checkbox"/> <input type="checkbox"/></p> <p>6. Does the student have any current skin problems (ex: itching, rashes, acne, warts, fungus or blisters)? <input type="checkbox"/> <input type="checkbox"/></p> <p>7. Is the student allergic to pollen, medicine, food or stinging insects? <input type="checkbox"/> <input type="checkbox"/> Does this require medical treatment? <input type="checkbox"/> <input type="checkbox"/> Has the student ever developed a rash or hives during or after exercise? <input type="checkbox"/> <input type="checkbox"/> Does the student cough, wheeze or have trouble breathing during or after activity? <input type="checkbox"/> <input type="checkbox"/> Has the student been diagnosed with asthma? <input type="checkbox"/> <input type="checkbox"/></p> <p>8. During or after exercise, has the student ever: passed out? <input type="checkbox"/> <input type="checkbox"/> been dizzy? <input type="checkbox"/> <input type="checkbox"/> had chest pain? <input type="checkbox"/> <input type="checkbox"/> Does the student get tired more quickly than friends do during exercise? <input type="checkbox"/> <input type="checkbox"/> Has the student ever: had racing of their heart or skipped heartbeats? <input type="checkbox"/> <input type="checkbox"/> had high blood pressure or elevated cholesterol? <input type="checkbox"/> <input type="checkbox"/> been told he/she has a heart murmur? <input type="checkbox"/> <input type="checkbox"/> Has any family member or relative: died of heart problems or of sudden death before age 50? <input type="checkbox"/> <input type="checkbox"/> been diagnosed with: hypertrophic cardiomyopathy (thick heart)? <input type="checkbox"/> <input type="checkbox"/> long Qt Syndrome? <input type="checkbox"/> <input type="checkbox"/> Marfan's Syndrome? <input type="checkbox"/> <input type="checkbox"/> Has the student had a severe viral infection (ex: myocarditis or mononucleosis) within the past month? <input type="checkbox"/> <input type="checkbox"/> Has a physician ever denied or restricted participation in sports for any heart problems? <input type="checkbox"/> <input type="checkbox"/></p> <p>9. Has the student ever: been knocked out, become unconscious or lost their memory? <input type="checkbox"/> <input type="checkbox"/> had a head injury or concussion? <input type="checkbox"/> <input type="checkbox"/> had a seizure? <input type="checkbox"/> <input type="checkbox"/> Does the student: ever have numbness, tingling in arms, hands, legs, or feet? <input type="checkbox"/> <input type="checkbox"/> have frequent or severe headaches? <input type="checkbox"/> <input type="checkbox"/> Has the student had a stinger, burner or pinched nerve? <input type="checkbox"/> <input type="checkbox"/></p>	<p>10. Does the student use any special protective or corrective equipment or devices that aren't usually used for their sport or position (ex: knee brace, special neck roll, foot orthotics, retainer on their teeth or hearing aid)? Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>11. Has the student: ever had a sprain, strain or swelling after an injury? <input type="checkbox"/> <input type="checkbox"/> broken or fractured any bones or dislocated any joints? <input type="checkbox"/> <input type="checkbox"/> had any other problems with pain or swelling in muscles, tendons, bones or joints? <input type="checkbox"/> <input type="checkbox"/></p> <p>If yes, check the box and explain.</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Head</td> <td><input type="checkbox"/> Elbow</td> <td><input type="checkbox"/> Thigh</td> </tr> <tr> <td><input type="checkbox"/> Neck</td> <td><input type="checkbox"/> Forearm</td> <td><input type="checkbox"/> Knee</td> </tr> <tr> <td><input type="checkbox"/> Back</td> <td><input type="checkbox"/> Wrist</td> <td><input type="checkbox"/> Shin/Calf</td> </tr> <tr> <td><input type="checkbox"/> Chest</td> <td><input type="checkbox"/> Hand</td> <td><input type="checkbox"/> Ankle</td> </tr> <tr> <td><input type="checkbox"/> Shoulder</td> <td><input type="checkbox"/> Finger</td> <td><input type="checkbox"/> Foot</td> </tr> <tr> <td><input type="checkbox"/> Upper arm</td> <td><input type="checkbox"/> Hip</td> <td></td> </tr> </table> <p>EXPLANATION FOR THOSE CHECKED: _____ _____ _____</p> <p>12. Has the student ever become ill from exercising in the heat? <input type="checkbox"/> <input type="checkbox"/></p> <p>13. Does the student complain of feeling stressed out? <input type="checkbox"/> <input type="checkbox"/></p> <p>14. FEMALES ONLY: When was the: first menstrual period? _____ <input type="checkbox"/> Haven't had it yet. most recent period? _____ How much time usually passes between the start of one period and the start of the next? _____ How many periods has the student had in the past year? _____ What was the longest time between periods in the past year? _____</p> <p>PLEASE EXPLAIN "YES" ANSWERS HERE:</p> <div style="border: 1px solid black; padding: 10px; margin-top: 10px;"> <p style="text-align: center;">I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.</p> <p>Signed:</p> <p>Student _____</p> <p>Parent/guardian _____</p> <p style="text-align: right;">DATE _____</p> </div>	<input type="checkbox"/> Head	<input type="checkbox"/> Elbow	<input type="checkbox"/> Thigh	<input type="checkbox"/> Neck	<input type="checkbox"/> Forearm	<input type="checkbox"/> Knee	<input type="checkbox"/> Back	<input type="checkbox"/> Wrist	<input type="checkbox"/> Shin/Calf	<input type="checkbox"/> Chest	<input type="checkbox"/> Hand	<input type="checkbox"/> Ankle	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Finger	<input type="checkbox"/> Foot	<input type="checkbox"/> Upper arm	<input type="checkbox"/> Hip	
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