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
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.) ☐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? ☐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?____________ ☐Haven't had it yet.		

PLEASE TURN THE PAGE OVER AND ANSWER MORE QUESTIONS!!

PHYSICIAN'S COMMENTS

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.

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

____

ASSESSMENT

1. See Physical Exam Summary and other side of this form for more information.
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________

PLAN

1. ☐Anticipatory Handouts given. ☐Discussed hazards of smoking
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________

7/07

PHYSICIAN'S SIGNATURE:____ DATE:______________

PATIENT NAME_______________________________________ BIRTH 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
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? ☐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? ☐Just right ☐Too thin ☐Too fat		
Has your weight changed this past year? ☐No change ☐Gained___pounds ☐Lost____pounds		
Have you ever been abused verbally, physically or sexually?		
Have you ever had sex? ☐I'd rather not answer that question.		

PHYSICIAN'S COMMENTS

☐Discussed the hazards of smoking, inhalants, alcohol and drugs.

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
H	LR IR HR/U	____________________
E	LR IR HR/U	____________________
A	LR IR HR/U	____________________
D	LR IR HR/U	____________________
S	LR IR HR/U	____________________
S/D	LR IR HR/U	____________________
SAFETY	LR IR HR/U	____________________

DIET

FAT_____
IRON_____
CALCIUM_____
CALORIC BALANCE______

STUDENT PREPARTICIPATION MEDICAL HISTORY

LINCOLN PEDIATRIC GROUP

4501 South 70th Street, Suite 110
Lincoln, NE 68516
Phone: 402-489-3834

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.**

Question	Yes	No
1. Has there been a medical illness or injury since the last check-up or sports physical?	☐	☐
2. Has the student ever: been hospitalized overnight?	☐	☐
had surgery?	☐	☐
3. Is the student currently using: prescription or over-the-counter medications/pills?	☐	☐
an inhaler?	☐	☐
supplements or vitamins to gain or lose weight?	☐	☐
or to improve athletic performance?	☐	☐
4. Does the student: lose weight regularly to meet weight requirements for a sport?	☐	☐
want to weigh more or less than at present?	☐	☐
5. Has the student had any problem with their eyes or vision?	☐	☐
6. Does the student have any current skin problems (ex: itching, rashes, acne, warts, fungus or blisters)?	☐	☐
7. Is the student allergic to pollen, medicine, food or stinging insects?	☐	☐
Does this require medical treatment?	☐	☐
Has the student ever developed a rash or hives during or after exercise?	☐	☐
Does the student cough, wheeze or have trouble breathing during or after activity?	☐	☐
Has the student been diagnosed with asthma?	☐	☐
8. During or after exercise, has the student ever: passed out?	☐	☐
been dizzy?	☐	☐
had chest pain ?	☐	☐
Does the student get tired more quickly than friends do during exercise?	☐	☐
Has the student ever: had racing of their heart or skipped heartbeats?	☐	☐
had high blood pressure or elevated cholesterol?	☐	☐
been told he/she has a heart murmur?	☐	☐
Has any family member or relative: died of heart problems or of sudden death before age 50?	☐	☐
been diagnosed with: hypertrophic cardiomyopathy (thick heart)?	☐	☐
long Qt Syndrome?	☐	☐
Marfan's Syndrome?	☐	☐
Has the student had a severe viral infection (ex: myocarditis or mononucleosis) within the past month?	☐	☐
Has a physician ever denied or restricted participation in sports for any heart problems?	☐	☐
9. Has the student ever: been knocked out, become unconscious or lost their memory?	☐	☐
had a head injury or concussion?	☐	☐
had a seizure?	☐	☐
Does the student: ever have numbness, tingling in arms, hands, legs, or feet?	☐	☐
have frequent or severe headaches?	☐	☐
Has the student had a stinger, burner or pinched nerve?	☐	☐
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)?	☐	☐
11. Has the student: ever had a sprain, strain or swelling after an injury?	☐	☐
broken or fractured any bones or dislocated any joints?	☐	☐
had any other problems with pain or swelling in muscles, tendons, bones or joints?	☐	☐

If yes, check the box and explain.

☐ Head	☐ Elbow	☐ Thigh
☐ Neck	☐ Forearm	☐ Knee
☐ Back	☐ Wrist	☐ Shin/Calf
☐ Chest	☐ Hand	☐ Ankle
☐ Shoulder	☐ Finger	☐ Foot
☐ Upper arm	☐ Hip	

EXPLANATION FOR THOSE CHECKED:______________________

Question	Yes	No
12. Has the student ever become ill from exercising in the heat?	☐	☐
13. Does the student complain of feeling stressed out?	☐	☐

14. **FEMALES ONLY:**

When was the: first menstrual period? __________ ☐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?

____

PLEASE EXPLAIN "YES" ANSWERS HERE:

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signed:

Student______________________________

Parent/guardian______________________________

DATE____________