Village PEDIATRICS

Name _____

12-17 Health assessment

Your doctor or other medical professional is asking these questions to discuss your personal health and safety not to judge you or your friends. Please answer the following questions.

What would you like to discuss with you doctor today?

1. Since your last visit, have there been any MAJOR illnesses, hospitalizations, changes or stresses for you or your family?	Yes	No
2. Have you ever had a reaction to a vaccine or needle. Including fainting?	Yes	No
3. Are you taking any vitamin supplements?	No	Yes
4. Are you taking any over-the-counter medications or performance enhancers or energy drinks?	Yes	No
5. Do you usually eat:		
a. At least 4 servings of Vitamin D per day (such as fatty fish, fortified diary products or cheese)?	No	Yes
b. Iron- rich foods such as meat, eggs, iron – fortified cereals or beans?	No	Yes
c. Multiple servings of fruit and vegetables every day?	No	Yes
d. Breakfast every day?	No	Yes
6. Do you drink more than one sugary drink on a daily basis (soda, tea, juice drinks)	Yes	No
7. Do you eat fast food more than once per week?	Yes	No
8. Have you ever been diagnosed with iron deficiency anemia?	Yes	No
9. Do you have serious concerns about your weight or body image?	Yes	No
10.Have you ever felt bad chest pain or fainted during sports or exercise?	Yes	No
11. Do you have a history of fainting during physical activity?	Yes	No
12. Has an immediate family member ever died suddenly during sports and exercise?	Yes	No
13. Has an immediate family member (mom, dad, brother, sister, or grandparent) had a heart attack, stroke, or unexplained sudden death at age 60 or younger?	Yes	No
14. Since your last physical have you been diagnosed with a concussion?	Yes	No
15. Does your family eat dinner with the TV on?	No	Yes
16. Is there a TV in your bedroom?	Yes	No
17. Do you usually spend more than two hours of non-school related screen time per day? (includes TV, video games, cellphone,computers, tablets)	Yes	No
18. Do you use ear buds or headphones with the sound turned up loud enough that the person next to you can hear it?	Yes	No
19. Do you brush your teeth with fluoride toothpaste every day?	No	Yes
20. Do you got to the dentist every 6 months?	No	Yes
21. Do you always wear a helmet when riding a bike,skateboard, rollerblades or scooter?	No	Yes

22. If you fell into deep water where you could not stand, could you save yourself? No Yes
23. Do you always wear a seat belt when driving a car? No Yes
24. Do you wear sunscreen when you might get a sunburn (beach, pool, outdoor sport)? No Yes
25. Do you talk or text on a cell phone when driving in the car? (for 15 + year olds) Yes No
26. Are all weapons and objects that could be of danger locked in a secure place in your home? No Yes
27. Do you play sports or do other physical activities such as walking, dancing or biking? No Yes
28. What grade are you in?_____ What grades do you make in school, GPA? _____

Important! Please fill out this side in private.

29. Have you ever been physically abused? Yes No
30. Have you ever been in trouble with the law? Yes No
31. have you smoked cigarettes, e-cigarettes or chewed tobacco in the past year? Yes No
32. During the past 12 months, did you
    a. Drink any alcohol (more than a few sips)? (Do not count sips of alcohol taken during family or religious events) Yes No
    b. Smoke any marijuana or hashish? Yes No
    c. Use anything else to get high? ("anything else" included illegal drugs, over the counter and prescription drugs,and things that you sniff or "huff") Yes No

CRAFFT

In the past 12 months:

33. Have you ever ridden in a car driven by someone (including yourself) who was high or had been using alcohol or drugs? Yes No
34. Do you ever use alcohol or drugs to relax, feel better about yourself , or fit in? Yes No
35. Do you ever use alcohol or drugs while you are by yourself or alone? Yes No
36. Do you ever forget things you did while using alcohol or drugs? Yes No
37. Do you ever use alcohol or drugs while you are by yourself or alone? No Yes
38. Do you ever forget thing you did while using drugs and alcohol? No Yes
39. Do your family or friends ever tell you that you should cut down on your drinking or drug use? Yes No
40. Have you ever gotten into trouble while you were using alcohol or drugs? Yes No
41. Have you ever been forced or pressured to have sex? Yes No
42. Have you ever had sex (including oral, vaginal or anal sex) ? Yes No
    a. If yes, do you or your partner always use a condom when you have sex? Yes No
    b. If yes, are you using birth control (besides a condom)? Yes No
43. Are you attracted to guys, girls or both? Guys Girls Both
44. Are your close friends gang members? Yes No
45. Do you, your parents or friends have a gun? Yes No

PHQ2

46. During the past two weeks, have you
    a) Felt down, depressed or hopeless? Yes No
    b.) Had little interest or found little pleasure in doing things? Yes No
47. Have you seriously thought about killing yourself, made a plan or tried to kill yourself? Yes No
48. Do you have any close friends or family members who have committed suicide? Yes No

For young women only

49. Have you started your period? (If no, you are finished) Yes No
    a. If yes at what age? _____
    b. Are your periods regular? No Yes
    c. Do you have any concerns about your period? Yes No