16-17 Year old Female Questionnaire

PARENTS, please complete the questions below about the patient:

Are you concerned about your child's... (circle concerns)

1. Eating habits, weight loss, weight gain, anorexia or bulimia? ☐ Yes ☐ No
2. Excessive or recurrent nose bleeds or easy bruising? ☐ Yes ☐ No
3. Recurrent ear, sinus, or strep infections? ☐ Yes ☐ No
4. Chest pain with exercise, shortness of breath, or irregular heart beat? ☐ Yes ☐ No
5. Wheezing, cough, excessive use of rescue inhalers? ☐ Yes ☐ No
6. Abdominal pain, vomiting, diarrhea, constipation? ☐ Yes ☐ No
7. Urinary control, bed wetting, urinary infections? ☐ Yes ☐ No
8. Joint pain, stiffness, swelling; muscle pain, weakness? ☐ Yes ☐ No
9. Birthmarks, skin rashes, acne, nail or hair problems? ☐ Yes ☐ No
10. Recurrent headaches, tics, weakness, or seizure disorder? ☐ Yes ☐ No
11. Mood changes, sadness, anxiety, fatigue, depression? ☐ Yes ☐ No
12. Excessive thirst or hunger, increased urination? ☐ Yes ☐ No
13. Paleness, easy bruising, swollen glands, weight loss? ☐ Yes ☐ No
14. Non-compliance of medication prescribed? ☐ Yes ☐ No
15. Change in friends, drug use, smoking, lying, stealing, and/or problems with school, the law or sexual activity? ☐ Yes ☐ No
16. Excessive pain from menses with missed days of school? ☐ Yes ☐ No

SCREENING QUESTIONS FOR TUBERCULOSIS:

1. Do you have a family member with TB or any contact with someone who has TB? ☐ Yes ☐ No
2. Do any family members have a positive TB test? ☐ Yes ☐ No
3. Was your child or any family members born in a high risk country (any country other than the US, Canada, Australia, New Zealand, or Western Europe)? ☐ Yes ☐ No
4. Has your child or a family member traveled to a high risk country and had contact with resident populations for over 1 week? ☐ Yes ☐ No
5. Has your child ever drank unpasteurized milk or eaten unpasteurized cheese? ☐ Yes ☐ No
6. Do you plan to travel to a high risk country (one NOT listed above) within the next year? ☐ Yes ☐ No

SPORTS PHYSICAL SCREENING QUESTIONS

1. Does your daughter have a history of high blood pressure? ☐ Yes ☐ No
2. Has your daughter ever fainted? ☐ Yes ☐ No
3. Does your daughter have chest pain with exercise? ☐ Yes ☐ No
4. Does your daughter have extreme shortness of breath with exercise? ☐ Yes ☐ No
5. Do you have a family history of sudden cardiac death prior to age 50? ☐ Yes ☐ No
6. Do you have a family history of cardiomyopathy, long QT syndrome, Marfans, or pacemakers in relatives under age 50? ☐ Yes ☐ No
7. Does your daughter have loss of function in one of any paired organs such as a kidney, eye, or ovary? ☐ Yes ☐ No

If your daughter is trying out for a sport, please list it here: _____

DIABETES/CHOLESTEROL SCREENING QUESTIONS:

1. Does either parent have high cholesterol? ☐ Yes ☐ No
2. Is there a family history of stroke or heart attack in women relatives under 65 years old or male relatives under 55 years old? ☐ Yes ☐ No
3. Are the questions asked above unknown? ☐ Yes ☐ No

YOUTH PEDIATRIC SYMPTOM CHECKLIST-17 (Y PSC-17)

Name: _____ Record #: _____

Date of Birth: _____ Today's Date: _____

Please mark under the heading that best fits you:		NEVER	SOMETIMES	OFTEN
◆	Fidgety, unable to sit still	0	1	2
❊	Feel sad, unhappy	0	1	2
◆	Daydream too much	0	1	2
❑	Refuse to share	0	1	2
❑	Do not understand other people's feelings	0	1	2
❊	Feel hopeless	0	1	2
◆	Have trouble concentrating	0	1	2
❑	Fight with other children	0	1	2
❊	Down on yourself	0	1	2
❑	Blame others for your troubles	0	1	2
❊	Seem to be having less fun	0	1	2
❑	Do not listen to rules	0	1	2
◆	Act as if driven by a motor	0	1	2
❑	Tease others	0	1	2
❊	Worry a lot	0	1	2
❑	Take things that do not belong to you	0	1	2
◆	Distract easily	0	1	2

OFFICE USE ONLY

Total ◆ _____ Total ❑ _____ Total ❊ _____ Grand Total ◆+❑+❊ _____

CONFIDENTIAL INFORMATION

16-17 YEAR OLD FEMALES:

PATIENTS complete the section below and HAND TO THE NURSE when you have completed the form. This form will be shredded after the doctor has read the form.

1. Do you have any school concerns (circle) such as poor grades, lack of motivation, loss of interest, difficulty concentrating, completing assignments, behavior, or excessive absences from school? ☐ Yes ☐ No
2. Do you have any concerns about your weight? ☐ Yes ☐ No
3. Do you have any body piercings (other than earrings) or tattoos? ☐ Yes ☐ No
4. In the past year have you tried to lose weight by vomiting, taking pills, laxatives, or starving yourself? ☐ Yes ☐ No
5. Do you have any concerns about (circle) your breasts, menstruation, pelvic pain, vaginal lesions (sores) or vaginal discharge? ☐ Yes ☐ No
   Do you have problems with menstruation such as excessive pain or excessive pain or flow or missed periods? ☐ Yes ☐ No
   When was your last menstrual period? _____
   Have you ever had a pelvic exam? ☐ Yes / Date: _____ ☐ No
6. Are you sexually active now? ☐ Yes ☐ No
   If you answered yes above, please answer the questions below:
   Does your partner always use a condom? ☐ Yes ☐ No
   Have you ever been pregnant? ☐ Yes ☐ No
   Do you have any children? ☐ Yes ☐ No
   Have you ever had an abortion? ☐ Yes ☐ No
   Have you ever been treated for a sexually transmitted disease? ☐ Yes ☐ No
   Are you taking oral contraceptives? ☐ Yes ☐ No
   Are you interested in starting oral contraceptives? ☐ Yes ☐ No
7. Do you have any concerns about inappropriate sexual behavior or sexual orientation? ☐ Yes ☐ No
8. Have you ever been physically or sexually mistreated or abused? ☐ Yes ☐ No
9. Do you have any social concerns: (lack of friends, poor relationships)? ☐ Yes ☐ No
10. Do you have any behavioral concerns: (temper outbursts, excessive risk taking)? ☐ Yes ☐ No
11. Do you smoke cigarettes? ☐ Yes ☐ No
12. Do you ever use marijuana, cocaine, inhalants, steroids, other? ☐ Yes ☐ No
13. Do you have concerns that you may not graduate from High School? ☐ Yes ☐ No
14. Do you drink alcohol? ☐ Yes ☐ No
    If yes, do you drink (circle all that apply): Beer Wine Liquor
    How often? Daily Weekly Rarely _____# of drinks
15. Have you been drunk in the past month? ☐ Yes ☐ No
16. Do you ever drive a vehicle when you have been drinking alcohol? ☐ Yes ☐ No
17. Do you always use a safety belt when riding in a car? ☐ Yes ☐ No
18. Does anyone have a gun in your home? ☐ Yes ☐ No
19. Do you exercise regularly? ☐ Yes ☐ No
20. How many ounces of milk do you drink in a day? _____ What kind of milk? _____
21. How many cups of soda/juice/energy drinks do you drink in a day? _____

Please tell us the names and ages of your brothers and sisters

_____

Patient lives with: Mom_____ Dad_____ Both Together_____ Both Separately_____

Do you have any concerns you wish to discuss? ☐ Yes ☐ No

_____

_____

Crestwood Pediatric
ASSOCIATES, PC

Patient Health Questionnaire-2

Name: _____ **Date:** _____

Over the past 2 weeks, how often have you been bothered by any of the following problems:

- **Little interest or pleasure in doing things**
  - **0 = Not at all**
  - **1 = Several days**
  - **2 = More than half the days**
  - **3 = Nearly every day**

- **Feeling down, depressed, or hopeless**
  - **0 = Not at all**
  - **1 = Several days**
  - **2 = More than half the days**
  - **3 = Nearly every day**

Adapted from the AAP Bright Futures Tool Kit