

10-12 Year Old MALE Questionnaire

Patient's Name: _____

Personal/Social History

Are you concerned about your child's...

- | | | |
|---|------------------------------|-----------------------------|
| 1. Wheezing/asthma | ☐ Yes | ☐ No |
| 2. Skin color or rashes (circle one)? | ☐ Yes | ☐ No |
| 3. Bed wetting, soiling or urinary control? | ☐ Yes | ☐ No |
| 4. Weight loss or gain? | ☐ Yes | ☐ No |
| 5. Nose bleeds or bruising? | ☐ Yes | ☐ No |
| 6. Behavior at school, home, or daycare? | ☐ Yes | ☐ No |
| 7. Food allergies? | ☐ Yes | ☐ No |
| 8. Seasonal allergies? | ☐ Yes | ☐ No |
| 9. Chronic abdominal pain? | ☐ Yes | ☐ No |
| 10. Joint pain, joint swelling or limp? | ☐ Yes | ☐ No |
| 11. Overall progress/happiness/performance at school? | ☐ Yes | ☐ No |
| 12. Poor diet and/or picky eating? | ☐ Yes | ☐ No |

Answer the following:

- | | | |
|---|------------------------------|-----------------------------|
| 13. Is your child exposed to tobacco smoke? | ☐ Yes | ☐ No |
| 14. Is your water source from a well? | ☐ Yes | ☐ No |

Does your child...

- | | | |
|--|------------------------------|-----------------------------|
| 15. Have any speech delays? | ☐ Yes | ☐ No |
| 16. Have problems sitting in his seat and paying attention at school? | ☐ Yes | ☐ No |
| 17. Have problems with his academic performance in school? | ☐ Yes | ☐ No |
| 18. Have problems with his school attendance? | ☐ Yes | ☐ No |
| 19. Seem unhappy or have problems with his self esteem? | ☐ Yes | ☐ No |
| 20. Have problems with bullying, withdrawal from family or friends? | ☐ Yes | ☐ No |
| 21. Have problems following the rules at school? | ☐ Yes | ☐ No |
| 22. Have problems with his temper or anger? | ☐ Yes | ☐ No |
| 23. Seem depressed or anxious? | ☐ Yes | ☐ No |
| 24. Does your child have more than 2 hours a day of screen time (computer, video games, television)? | ☐ Yes | ☐ No |

Answer the following:

- | | |
|--|--|
| 25. Do you have smoke alarms? _____ | Carbon monoxide detectors? _____ |
| 26. Do you know CPR? | ☐ Yes ☐ No |
| 27. Are you giving your child a multivitamin with iron? | ☐ Yes ☐ No |
| 28. Is your child eating all food groups: fruits, meats, and vegetables? | ☐ Yes ☐ No |
| 29. Is your child brushing his teeth? | ☐ Yes ☐ No |
| 30. Is your child seeing the dentist every 6 months? | ☐ Yes ☐ No |
| 31. Does your child consistently use a seat belt and ride only in the back seat? | ☐ Yes ☐ No |
| 32. Does your child always use a bike helmet when riding a bike? | ☐ Yes ☐ No |
| 33. How many ounces of milk does your child drink in one day? _____ | What kind? _____ |
| 34. How many ounces of juice does your child drink in one day? _____ | |

10-12 Year Old MALE Questionnaire

Does your child...

35. Interact positively with teachers and friends and babysitters and siblings? ☐ Yes ☐ No
36. Run well and keep up with her friends? ☐ Yes ☐ No
37. Have adult supervision before and after school? ☐ Yes ☐ No
38. Have regular chores? ☐ Yes ☐ No
39. Have you counseled your child about avoiding alcohol, tobacco, drugs, inhalants, and sex? ☐ Yes ☐ No
40. Have you counseled your son on puberty? ☐ 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

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 under 65 or male relatives under 55?..... ☐ Yes ☐ No
3. Are the questions asked above unknown? ☐ Yes ☐ No

Sports Physical Screening Questions:

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

If your son will be trying out for a sport, please list the sport here: _____

Name and Ages of Brothers _____

Sisters _____

Patient lives with: Mom _____ Dad _____ Both Together _____ Both Separately _____

Do you have any concerns you wish to discuss? ☐ 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

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Total ◆ _____ Total □ _____ Total ✱ _____ Grand Total ◆+□+✱ _____