

13-15 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