10-12 Year Old FEMALE 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 her seat and paying attention at school? ..... ☐ Yes ☐ No
17. Have problems with her academic performance in school? ..... ☐ Yes ☐ No
18. Have problems with her school attendance? ..... ☐ Yes ☐ No
19. Seem unhappy or have problems with her 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 her 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 her 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? _____

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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 daughter on menstruation and puberty? ..... ☐ Yes ☐ No
    - Has menstruation begun? ..... ☐ Yes ☐ No
    - If yes, does she have severe cramps? ..... ☐ Yes ☐ No
    - Does she bleed more often than every 21 days, or longer than 14 days? ..... ☐ Yes ☐ No
    - Does she miss more than 3 months between periods? ..... ☐ 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 ovary? ..... ☐ Yes ☐ No

If your daughter 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

OFFICE USE ONLY

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