

16-17 Year old Male Questionnaire for PARENTS

**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

**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 son have a history of high blood pressure?.....  Yes  No
- 2. Has your son ever fainted?.....  Yes  No
- 3. Does your son have chest pain with exercise?.....  Yes  No
- 4. Does your son 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 son have loss of function in one of any paired organs such as a kidney,  
eye, or testicle? .....  Yes  No

If your son 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