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