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 cigarette 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

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

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. Do you have a history of high blood pressure? ....☐ Yes ☐ No
2. Have you ever fainted?..☐ Yes ☐ No
3. Do you have chest pain with exercise? ....☐ Yes ☐ No
4. Do you 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 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

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