

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?
36. Run well and keep up with her friends?
37. Have adult supervision before and after school?
38. Have regular chores?
39. Have you counseled your child about avoiding alcohol, tobacco, drugs, inhalants, and sex?
40. Have you counseled your daughter on menstruation and puberty?
Has menstruation begun?
If yes, does she have severe cramps?
Does she bleed more often than every 21 days, or longer than 14 days?
Does she miss more than 3 months between periods?

Screening questions for Tuberculosis:

- 1. Do you have a family member with TB or any contact with someone who has TB?
2. Do any family members have a positive TB test?
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)?
4. Has your child or a family member traveled to a high risk country and had contact with resident populations for over 1 week?
5. Has your child ever drank unpasteurized milk or eaten unpasteurized cheese?
6. Do you plan to travel to a high risk country (one NOT listed above) within the next year?

Diabetes/Cholesterol Screening Questions:

- 1. Does either parent have high cholesterol?
2. Is there a family history of stroke or heart attack in women under 65 or male relatives under 55?
3. Are the questions asked above unknown?

Sports Physical Screening Questions:

- 1. Does your child have a history of high blood pressure?
2. Has your child ever fainted?
3. Does your child have chest pain with exercise?
4. Does your child have extreme shortness of breath with exercise?
5. Does your child have a family history of sudden cardiac death prior to age 50?
6. Does your child have a family history of cardiomyopathy, long QT syndrome, Marfans, or pacemakers in relatives under age 50?
7. Does your child have loss of function in one of any paired organs such as a kidney, eye, or ovary?

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?

Four horizontal lines for writing concerns.