13-15 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