Name: _____ Date of birth: _____

Health Status Questionnaire – 11-14 Years

Child lives with: mother father both parents other:_____

School: public private chartered home school
Grade: 5th 6th 7th 8th 9th
Performance: excellent good fair poor failing

Eating habits:
___ regular meals ___ snacks ___ grazes ___ skips meals ___ picky
___adequate fruits/veggies ___ mostly meat/carbs ___ fast food > 2x week
Milk/dairy products: ___ times per day ___ vegetarian

Activity: regular exercise active sports sedentary cannot tolerate exercise

Voiding habits: normal bedwetting accidents during day

Stool pattern: regular irregular hard constipation diarrhea

Sleep: 8-10 hours <8 hours difficulty falling asleep wakes at night

Firearms/guns in home: Y N Locked away: Y N
Insect protection: Y N Helmet use: Y N
Sunscreen: Y N ATV/motorcycle: Y N
Seat belt use: Y N Passive smoke exposure: Y N
Dental visit: Y N

Tuberculosis (Tb) Screen Questions:
Has your child ever received BCG (a Tb vaccine given in some foreign countries)? Y N
Has there ever been tuberculosis/Tb in any household member? Y N
Was your child born or traveled for longer than 2 weeks to a country at high risk for tuberculosis (countries other than U.S., Canada, Australia, New Zealand or western Europe)? Y N

Smoking status: Y N Aware of risks of drugs/alcohol: Y N

Do you limit your child to no more than 1-2 hrs of TV/computer/video games? Y N
Do you supervise your child's computer/internet activity? Y N

(continue on back)

Review of Systems:

Const			*GI*			*Heme*		
fever	y	n	stomachache	y	n	excessive bleeding	y	n
fatigue	y	n	heartburn	y	n	excessive bruising	y	n
weight loss	y	n	diarrhea	y	n	pale	y	n
weight gain	y	n	constipation	y	n	swollen		
nightsweats	y	n	nausea	y	n	lymph nodes	y	n
			vomiting	y	n	*GU*		
ENT/eye						urination pain	y	n
blurred vision	y	n	*Skin*			discharge	y	n
eye irritation	y	n	acne	y	n	itching	y	n
snoring	y	n	eczema	y	n	genital sores	y	n
sore throat	y	n	rash	y	n	scrotum swelling	y	n
earache	y	n	suspicious			irregular periods	y	n
hearing loss	y	n	lesion	y	n	*Allergy*		
stuffy nose	y	n				hay fever	y	n
nosebleeds	y	n	*Musc-skel*			sinus congestion	y	n
			limp	y	n	food reaction	y	n
Resp			injury	y	n	hives	y	n
cough	y	n	knee pain	y	n			
night cough	y	n	joint pain	y	n	*Mental health*		
exercise coughy		n	joint swelling	y	n	mood swings	y	n
wheezing	y	n				depression	y	n
labor breathingy		n	*Neuro*			suicidal thought	y	n
CV			headaches	y	n	racing thought	y	n
palpitation	y	n	change in gait	y	n	anger	y	n
dizziness	y	n	weakness	y	n	compulsive habits	y	n
passing out	y	n	seizure	y	n	anxiety	y	n
chest pain	y	n						

Do you have any concerns about your child? _____

If your child has asthma, history of wheezing or uses inhalers/breathing treatments, please answer the following questions:

Cough/wheezing: 0-2 days/week >2 days/week daily throughout day
Nighttime cough: 0-1 night/month 2-3 nights/month 4 nights/month >1 night/week
Interferes with normal activity: no limitations minor some extreme
Rescue inhaler (albuterol,Proair,Xopenex,Ventolin,Proventil) use:
0-2 days/week >2 days/week daily several times/day
Oral steroid courses: 0-1X/year 2-3X/year >3X/year
Asthma hospitalizations past 6 months: 0 1 2 3

Updated 8/28/17