14-18 Year Pre-Visit Questionnaire

Eastern Shore Children's Clinic

For us to provide you with the best possible care we would like to know how things are going. We recommend that patients complete this form alone, answers will be kept confidential.

PATIENT'S NAME:_____ DATE OF BIRTH:_____

Do you have any concerns, questions or problems that you would like to discuss today? Please describe:_____
_____
_____

Do you have any allergies? YES/NO If yes, please list:_____
Do you take any medications? YES/NO If yes, please list:_____
Do you see any other health care providers? YES/NO If yes, please List:_____

Have there been any recent changes in your family? (check all that apply)

____ Death ____ Divorce Other: _____
____ Job Change ____ Move _____

DIET/NUTRITION

	Yes	No
Do you eat foods with iron like meat, eggs or beans?		
Do you eat meals together as a family?		
Do you have questions or concerns about the size or shape of your body?		

BEHAVIOR/SOCIAL

	Yes	No
Do you have concerns about your hearing?		
Do you have concerns about your vision?		
Are you having any problems at school?		
Are you having trouble concentrating?		
Do you worry a lot or feel overly stressed out?		

In the past 2 weeks , how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Little interest of pleasure in doing things				
Feeling down, depressed or hopeless				

In the past 12 months did you:

	Yes	No
Drink any alcohol, more than a few sips?		
Use any marijuana or hashish?		
Use anything else to get high (includes illegal drugs, over the counter drugs, prescriptions drugs, and things your huff or sniff to get high)?		

	Yes	No
Has a family member or contact had tb or had a + skin test?		
Were you born in a country at high risk for tb (any country other than the US, Canada, Australia, New Zealand or Western Europe)?		
Have you traveled to a country other than the US, Canada, Australia, New Zealand or Western Europe and stayed longer than a week?		

	Yes	No
Have you seen a dentist in the past year?		
Do you brush your teeth at least twice a day?		

Do you have parents or grandparents who have had a stroke or heart problem before age 55?		
Do you have a parent with an elevated blood cholesterol or who is taking cholesterol medication?		
Do you spend time with people who smoke?		

FOR GIRLS

	Yes	No
Have you started having periods?		
Do you have any questions about your periods or menstruation?		