15-17 Year Pre-Visit Questionnaire

Instructions: *Please answer the questions below by circling or putting an X on the correct choice. These questions help us assess your health, development, and safety.*

General Health

1	Do you have any concerns about your health today?	NO	YES
2	Do you receive health care from anyone besides a medical doctor (acupuncturist, chiropractor, naturopath)?	NO	YES

Feeding/Nutrition

3	Do you eat 5 or more helpings of fruits/vegetables each day?	YES	NO
4	Are your breads, pastas, cereals mostly whole grain?	YES	NO
5	Do you eat or drink at least 2-3 servings of calcium rich food per day (beans, green leafy vegetables, milk, yogurt, cheese)?	YES	NO
6	Do you eat junk foods (chips, cookies, crackers, candy) and/or fast foods more than once or twice per week?	NO	YES
7	Do you snack more than 2 times a day?	NO	YES
8	Do you drink soda, juice or other sweetened drinks more than once or twice per week?	NO	YES
9	Do you eat meals together as a family?	YES	NO
10	Do you have any concerns or questions about the size or shape of your body?	NO	YES
11	In the past year have you tried to control your weight by vomiting, taking diet pills or laxatives, or starving yourself?	NO	YES
12	Are you taking any vitamins or supplements?	NO	YES

Oral Health

13	Do you brush your teeth with fluoride toothpaste twice a day and floss once a day?	YES	NO
14	Do you see a dentist at least twice a year?	YES	NO

Activity

15 Do you play any competitive sports?	NO	YES
16 Is there any family history of heart problems or sudden death?	NO	YES
17 Do you watch TV, play video games, or spend time on the computer more than 2 hours per day (not including screen time for homework)?	NO	YES
a. Do you have a TV, video game machine, or computer in your room?	NO	YES
18 Are you active (exercising/heart rate elevated) for at least 1 hour every day?	YES	NO
19 Do you have a hard falling asleep or staying asleep at night?	NO	YES
20 Are you sleeping 9-11 hours at night?	YES	NO

School

21 Are you having problems in school or work?	NO	YES
22 Are your grades worse than last year?	NO	YES
23 Do you have trouble concentrating?	NO	YES
24 Have you been getting into fights?	NO	YES
25 Do you have problems doing your homework?	NO	YES
26 Have you been suspended in the past year?	NO	YES
27 Have you missed more than a few days of school in the last year?	NO	YES
28 Do you have an IEP or other learning plan?	NO	YES

Injury Prevention

29 Do you always wear a seat belt when you are in a car?	YES	NO	
30 Do you wear a helmet when you play team sports, in-line skate, skateboard, bicycle, ski, snowboard, or ride a motorcycle, ATV, minibike, or snowmobile?	YES	NO	
31 Do you ever carry a gun?	NO	YES	
32 If there is a gun in your home, is it locked in a safe with the ammunition stored separately?	N/A	NO	YES
33 Have you started to learn how to drive or do you drive?	NO	YES	
a. Have you ever used a cellphone, texted, or used headphones while you were driving?	NO	YES	

Tuberculosis

34 Has a family member or contact had tuberculosis disease (TB)?	NO	YES
35 Has a family member ever had a positive TB skin test (PPD)?	NO	YES
36 Were you born in a high-risk country (countries other than the U.S., Canada, Australia, or Western Europe)?	NO	YES
37 Have you traveled to a high-risk country for more than a week?	NO	YES

Emotional Wellbeing

38 Do you feel stressed out, anxious or overly worried?	NO	YES
39 Does your nervousness/worrying make it hard for you to do well in school/at home/or with your other activities?	NO	YES
40 When you are angry, do you do violent things?	NO	YES
41 Have you ever seriously thought about hurting or killing yourself or someone else?	NO	YES
42 Do you get along with your family and follow their rules?	YES	NO
43 Have you experienced bullying or harassment on social media (Facebook, Snapchat, Intagram, etc?)	NO	YES
44 Is there someone you are dating or a person at home or at school that is hurting you?	NO	YES

Review of Systems

45 Do you have any concerns about eating habits, weight loss, or lack of energy?	NO	YES
46 Do you have any sleep problems, including a lot of snoring?	NO	YES
47 Have you had any concerns of your eyes or vision?	NO	YES
48 Have you had recurrent ear, sinus or throat infections, nosebleeds?	NO	YES
49 Have you had chest pain, shortness of breath, or irregular heartbeat?	NO	YES
50 Have you had frequent colds, cough, wheezing, recurrent lung infections?	NO	YES
51 Have you had abdominal (stomach) pain, vomiting, diarrhea, constipation?	NO	YES
52 Have you had any kidney or bladder problems, infections, or blood in your urine (pee)?	NO	YES
53 Have you had any concerns about your skin, hair, or nails?	NO	YES
54 Have you had any joint pain, stiffness, swelling, muscle pain or weakness?	NO	YES
55 Have you had any recurrent headaches, dizziness, tics, weakness, seizures?	NO	YES

56 Do you have anxiety, mood changes, sadness, nervous problems or issues with anger/temper?	NO	YES
57 Have you had excessive thirst or increased urination?	NO	YES
58 Have you had paleness, anemia, easy bruising, swollen glands?	NO	YES
59 Do you have concerns about puberty?	NO	YES

For girls:

60 Have you gotten your period?	YES	NO
61 Do you have any problems or questions about menstruation (getting your period)?	NO	YES
62 Do you get your periods every 21-42 days?	YES	NO
63 When was your last period?		