Boulevard Center Pediatrics, Inc.

"Where your children are the center of our attention."

WELL VISIT QUESTIONNAIRE (AGES 11 AND UP) Today's Date:___________

First Name:_______________________________ Last Name:___________________________D.O.B:_________________

Address:____ Tel No.________________________________

MEDICAL HISTORY

1. Any medical problems/concerns today? If yes, please specify____ No / Yes
2. Any previous allergies? (Including Food & Medication)____ No / Yes
3. Are you currently taking any medications? Please List:____ No / Yes
3. Any previous major injury/fracture/concussion? (Specify When)____ No / Yes
4. Any previous hospital admission? (When & Why?)____ No / Yes
5. Any previous surgery?____ No / Yes
6. Do you have any hearing or vision issues? (Recommended to see a Eye Doctor for Vision Issues) No / Yes
7. Have you seen a Dentist in the past 12 months? (Recommended to brush teeth daily & see dentist) Yes / No
8. FOR GIRLS: Date of Last Menstrual Period_______________ Are your periods regular(monthly?) Yes / No
   Have you had a miscarriage, abortion or live birth in the past 1 year?_______________ No / Yes

TUBERCULOSIS SCREENING (If yes for any question below, you may need a TB test.)

1. Have you been abroad (outside US/Canada) for more than 1 month in the last 5 years?Where?__________________ No / Yes
2. Are you in close contact of a person known to have TB/currently under treatment? No / Yes
3. Are you in close contact of a high risk person for TB (person with HIV, Drug User/ Prison Inmate) No / Yes

DIET/ELIMINATION/SLEEP

1. Do you have healthy eating habits? (Eat fruits and vegetables regularly?) Yes / No
2. Do you have regular, easy bowel movements (passing stool?) Yes / No
3. Do you have regular sleep habits and sleep hours? Yes / No

HEALTH PROFILE

1. Do you ever eat in secret? No / Yes
2. Do you often think about ways to be thin? No / Yes
3. Have you tried to lose weight by forcing yourself to vomit, use diet pills/laxative/stare at yourself? No/ Yes
4. Do you exercise or play sports for ½ hr at least 3 times a week? Yes / No
5. Have your grades become worse this year? No / Yes
6. Do you have or suspect you may have a learning problem? No / Yes
7. Have you been suspended from school in the past 2 years? No / Yes

FRIENDS & FAMILY

1. Do you have at least 1 friend who you really like and feel you can talk to? Yes / No
2. Do you think your parent/guardian usually listens to you and takes your feeling seriously? Yes / No
3. Have you ever thought about running away from home? No / Yes

SAFETY

1. Do you or anyone you live with have a gun, rifle or other firearm? No / Yes
2. Have you carried a gun, knife or other weapon for protection in the past year? No / Yes
3. Have you been in a physical fight in the past 3 months? No / Yes
4. Have you ever been in trouble with the law? No/ Yes
5. Are you worried about violence or your safety? No / Yes
6. Do you wear a helmet when you rollerblade/skateboard/ride motorcycle or ATV? No / Yes

TOBACCO

1. Do you ever smoke cigarettes/cigars, use snuff or chew tobacco? No / Yes
2. Do any of your close friends smoke cigarettes/cigars, use snuff or chew tobacco? No / Yes
3. Do anyone you live with smoke cigarettes/cigars, use snuff or chew tobacco? No / Yes

ALCOHOL & DRUGS

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1. In the past month, have you gotten drunk on beer, wine or any other alcohol? No / Yes
2. In the past month, have any of your close friends gotten drunk on beer, wine or any other alcohol? No / Yes
3. Have you ever been criticized or gotten into trouble because of drinking? No / Yes
4. In the past year, have you used alcohol and then driven a car/truck or motorcycle? No / Yes
5. In the past year, have you been in a car/vehicle where the driver had been drinking alcohol/using drugs? No / Yes
6. Does anyone in your family drink or take drugs so much that it worries you? No / Yes
7. Do you ever use marijuana or other drugs or sniff inhalants? No / Yes
8. Do any of your close friends use marijuana or other drugs or sniff inhalants? No / Yes / Unsure
9. Do you ever use non prescription drugs to get to sleep, stay awake, calm down or get high? No / Yes
10. Have you ever used steroid pills or shots without a doctor telling you to? No / Yes

DEVELOPMENT

1. Do you have any concerns about your size/shape of your body or your physical appearance? No / Yes / Unsure
2. Have you pierced your body (not including ears) or gotten a permanent tattoo? No / Yes
3. Do you think you may be gay, lesbian or bisexual? No / Yes / Unsure
4. Have you ever had sexual intercourse? (If yes, then how old were you the 1st time)______________ No / Yes / Unsure
5. Have any of your close friends had sexual intercourse? No / Yes / Unsure
6. If you are sexually active:
   a. Do you/your partner always use condoms during sex Yes / No / Unsure
   b. Have you ever been pregnant or gotten someone pregnant? No / Yes / Unsure
   c. Have you ever been told by a doctor/nurse that you have a Sexually Transmitted Infection? No / Yes / Unsure

EMOTIONS: Over the past 2 weeks, how often have you been bothered by any of the following? Use a “√” to indicate answer.
Check: 0 = Not AT All 1= For Several Days 2 = More than Half of the Days 3 = Nearly Daily

Question	0	1	2	3
Little interest or lack of pleasure in doing things?				
Feeling down depressed or hopeless?				
Trouble falling asleep or staying asleep too much?				
Poor appetite or overeating?				
Feeling tired or having little energy?				
Feeling bad about yourself/ feeling you are a failure/ have let yourself or your family down?				
Trouble concentrating on things such as school/work/reading/watching TV?				
Moving or speaking slowly so that other people could notice or Being so fidgety/restless that you have been moving around a lot more than usual?				
Thoughts that you would be better off dead or hurting yourself in some way?				

1. In the past year, have you felt sad/depressed most days even if you felt ok sometimes? No / Yes
2. If you are experiencing any problems in the chart above, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people? Not Difficult Somewhat Difficult Very Difficult Extremely Difficult
3. Has there been a time in the past month that you had serious thoughts about ending your life? No / Yes
4. Have you ever in your life tried to kill yourself or made a suicide attempt? No / Yes
5. Have you ever been physically/sexually/emotionally abused? When?___________________________________ No / Yes

SPORTS

1. Do you participate in sports? Which Sports?____ No / Yes
2. Do you get any chest pain, trouble breathing, shortness of breath or abnormal heart beats during sports/activity? No / Yes
3. Have you ever felt dizzy or fainted during sports? No / Yes
4. Do you have any weakness of muscles or body parts or numbness/tingling in any body parts? No / Yes
5. Do you have any limitation of movements of any joint or pain on movement of any body joint? No / Yes
6. Have any of your family members have a heart rhythm problem/ died during sports/ has a sudden death at a young age? No / Yes

FAMILY HISTORY (list any chronic medical problems for family members: A = Asthma/Allergies, T = Thyroid, HC = High Cholesterol, D = Diabetes, BP = High Blood Pressure, M = Migraines, C = Cancer, O = Other

Mother:________________________________Father:____________________________Siblings:__________________________

Grandmother:________________________________ Grandfather:____