



11-13 Year Pre-Visit Questionnaire

For us to provide you with the best possible care we would like to know how things are going. At this age we recommend that parents and patients complete this form together. Starting at age 14 we recommend that patients complete the forms alone for privacy.

CHILD'S NAME: _____ DATE OF BIRTH: _____

YOUR NAME: _____ RELATIONSHIP: _____

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				

	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?		

	Yes	No
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?		