Health Maintenance Questionnaire

ADOLESCENT Female

PATIENT NAME: TODAY'S DATE:
PARENTS: Birth Date: Age today:
REASON FOR THIS CHECK UP: ☐School ☐Sports ☐Camp ☐Routine check-up ☐Other: Grade: School:

CONCERNS

List concerns you have: 1.
2.
3.

Please check any body areas that concern you:

☐head	☐nose	☐heart	☐kidneys	☐bones	☐brain	☐hormones
☐eyes	☐mouth	☐lungs	☐genitals	☐joints	☐nerves	☐blood
☐ears	☐throat	☐intestines	☐skin	☐muscles	☐mental health	☐glands/immunity

LEARNING & BEHAVIOR

Who do you live with?
Do you get along with your parents or custodians?
What activities are you involved in and like to do for fun?
Learning or behavior problems at school:
Do you have trouble making or keeping friends?
Do you get into fights often?
Grades are: ☐Excellent ☐Good ☐Fair ☐Poor ☐Failing
Comments:

HEALTH & SAFETY

Do your friends:	Yes No		Yes No		Yes No
-smoke or use tobacco?	☐☐	Do you?	☐☐	Family members?	☐☐
-sniff glue or use inhalants?	☐☐	Have you?	☐☐	Family members?	☐☐
-drink alcohol?	☐☐	Have you?	☐☐	Family members?	☐☐
-use drugs?	☐☐	Have you?	☐☐	Family members?	☐☐

Are guns at home locked up with bullets stored separately? ☐No guns in home. ☐☐

Do you --have smoke detectors and a fire escape plan at your house? ☐☐
--know how to swim? ☐☐
--wear a helmet when you ride a bike? ☐ don't ride one. ☐☐
--always wear a seat belt? ☐☐

Have you ever been abused verbally, physically or sexually? ☐☐

Gynecology questions	Yes No
Do you have questions or concerns about your periods?	☐☐
Do you have vaginal itching, burning or discharge?	☐☐
Have you ever felt a lump in your breast?	☐☐
Have you had a "pelvic exam" or a PAP smear?	☐☐
Do you have questions about sexuality?	☐☐

Gynecology education

-Irregular periods are common during the first 2 years.
-Clear/white discharge is normal during the year before your first period.
-Breast cancer is rare in teens. Start doing self-breast exams after age 20.
-A pelvic exam is recommended by age 21, or sooner if having sex or any concerns.
-A PAP smear is recommended within 3 years of having sex.
-The Gardasil vaccine prevents cervical cancer.

Explain questions answered with "yes." Give approximate dates.

PHQ-9

Not at All	Several Days	More Than Half the Days	Nearly Every Day	**Over the last 2 weeks, how often have you been bothered by any of the following problems?**
☐0	☐1	☐2	☐3	1. Little interest or pleasure in doing things
☐0	☐1	☐2	☐3	2. Feeling down, depressed, or hopeless
☐0	☐1	☐2	☐3	3. Trouble falling or staying asleep, or sleeping too much
☐0	☐1	☐2	☐3	4. Feeling tired or having little energy
☐0	☐1	☐2	☐3	5. Poor appetite or overeating
☐0	☐1	☐2	☐3	6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down
☐0	☐1	☐2	☐3	7. Trouble concentrating on things, such as reading the newspaper or watching television
☐0	☐1	☐2	☐3	8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual
☐0	☐1	☐2	☐3	9. Thoughts that you would be better off dead, or of hurting yourself in some way

Not difficult at all ☐
Somewhat difficult ☐
Very difficult ☐
Extremely difficult ☐

If you checked off any problems, 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?

NURSE: Add the numbers above and write the total here:_____

TUBERCULOSIS (TB) RISK

	Yes No
Have you been around anyone with contagious TB or a positive PPD test?	☐☐
Have you had contact with people from Asia, Middle East, Africa or Latin America?	☐☐
Is anyone living in your house infected with HIV?	☐☐
Have you been exposed to any of the following people: homeless, nursing home residents, institutionalized people, jail/prison inmates, users of illicit drugs, migrant farm workers.	☐☐
Do you have cancer,diabetes,kidney failure, HIV, poor nutrition or immunosuppressed?	☐☐

TB Risk: High
Low

PHYSICAL EXAM

Ht_____ Wt_____ VS:_____

Head	Nose	Lungs	Back
Eyes/Red reflexes	Mouth	Heart	Hips
Ears	Throat	Femoral pulses	Extremities
	Neck	Abdomen	Skin
	Chest	Genitalia	Neurologic

Vision / Hearing

☐With glasses
Nr: L ___/____ R___/____
Far: L___/____ R___/____
500 1000 2000 4000
L
R

LAB

Hgb
UA
Cholesterol
PPD placed

IMMUNIZATIONS

☐Given at Health Department
Shots up to date? ☐Yes ☐No
Any previous side effects? ☐Yes ☐No
If yes, what?

6/15

ASSESSMENT

PLAN

Student Preparticipation Medical History

LINCOLN PEDIATRIC GROUP
4501 So.70th St, Ste.110
Lincoln, NE 68516
Phone: 402-489-3834

STUDENT NAME_____ ☐MALE ☐FEMALE
BIRTH DATE_____/_____/_____ GRADE_____AGE_____
SCHOOL_____ ACTIVITY_____

STUDENT MEDICAL QUESTIONNAIRE

*Circle questions you don't know the answers to. Explain "Yes" answers below.

Everyone completes this column.	Yes	No
Have you seen doctor outside of LPG for any reason?	☐	☐
1. Do you have a recurrent medical or psychological problem?	☐	☐
Has there been a medical illness or injury since the last check-up?	☐	☐
2. Have you ever: been hospitalized overnight?	☐	☐
had surgery?	☐	☐
3. Are you currently using: an inhaler?	☐	☐
prescription or over-the-counter medications/pills?	☐	☐
supplements or vitamins to gain or lose weight?	☐	☐
or to improve athletic performance?	☐	☐
4. Do you: want to weigh more or less than at present?	☐	☐
lose weight regularly to meet weight requirements for a sport?	☐	☐
avoid any foods groups? (fruit/veg, meat, milk/dairy, fats, bread/grain)	☐	☐
5. Have you had any problems with -- your eyes or vision?	☐	☐
-- your hearing?	☐	☐
Has it been more than 1 year since your last dental check-up?	☐	☐
What is your source of fluoride? ☐no known fluoride ☐not sure ☐city water ☐fluoride rinse / recs from dentist ☐natural fluoride in water source ☐fluoride vitamin		
6. Do you have any current skin problems (ex: itching, rashes, acne, warts, fungus or blisters)?	☐	☐
7. Are there allergies to pollen, medicine, food, stinging insects?	☐	☐
Does this require medical treatment?	☐	☐
Have you been diagnosed with asthma?	☐	☐
During or after exercise: -have you ever developed a rash or hives?	☐	☐
8. -do you cough, wheeze or have trouble breathing?	☐	☐
-have you ever -- passed out?	☐	☐
--been dizzy?	☐	☐
--had chest pain ?	☐	☐
Do you get tired more quickly than friends do during exercise?	☐	☐
9.Have YOU ever: been told you have a heart murmur?	☐	☐
had racing of their heart or skipped heartbeats?	☐	☐
had high blood pressure or elevated cholesterol?	☐	☐
10. Has a RELATIVE: -had diabetes?	☐	☐
-been very obese?	☐	☐
-had high cholesterol?	☐	☐
-died of heart problems or of sudden death before age 50?	☐	☐
-been diagnosed with: long Qt Syndrome?	☐	☐
hypertrophic cardiomyopathy (thick heart)?	☐	☐
Marfan's Syndrome?	☐	☐

Complete this column for SPORTS participation.	Yes	No
11. Have you: had a sprain, strain or swelling after an injury?	☐	☐
broken or fractured any bones or dislocated any joints?	☐	☐
had pain or swelling in muscles, tendons, bones or joints?	☐	☐

If yes, check the box and explain. EXPLAIN:

☐ Head ☐ Shoulder ☐ Hip
☐ Neck ☐ Upper arm ☐ Thigh
☐ Back ☐ Elbow Wrist ☐ Knee
☐ Chest ☐ Forearm ☐ Shin/Calf
☐ Hand ☐ Ankle
☐ Finger ☐ Foot

	Yes	No
12. Do you use any special protective or corrective equipment or devices that aren't usually used for their sport or position? (ex: knee brace, neck roll, foot orthotics, teeth retainer or hearing aid)	☐	☐
13.Have you had a severe viral infection (ex: myocarditis or mononucleosis) within the past month?	☐	☐
14. Has a physician ever denied or restricted participation in sports for any heart problems?	☐	☐
15. Have you ever: had a head injury or concussion?	☐	☐
been knocked out, become unconscious or lost your memory?	☐	☐
had a seizure?	☐	☐
had a stinger, burner or pinched nerve?	☐	☐
16. become ill from exercising in the heat?	☐	☐
17. Do you: have frequent or severe headaches?	☐	☐
ever have numbness, tingling in arms, hands, legs, or feet?	☐	☐
18. Do you ever feel stressed out?	☐	☐

PLEASE EXPLAIN "YES" ANSWERS HERE:

14. **FEMALES ONLY:** ☐Have not had a period. Skip this section.
When was the: first menstrual period?
most recent period?
How much time usually passes between the start of one period and the start of the next?
What was the longest time between periods this past year?
How many periods have you had in the past year?
How many days does your period usually last?
Do you get cramps which interfere with activities?
If yes, what medications have you tried?

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. The information provided here may be shared with other school personnel as needed to promote the child's safety and educational success at school.

Signed:
Student_____
Parent/guardian_____
DATE