Health Maintenance Questionnaire

Adolescent Male
Age 11 and older

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 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

List prescription and over the counter MEDS here:

Pills:
Inhaler:
Nasal spray:
Eye/ear drops:
Skin treatments:
Herbal/Vits/Supplements:
Injectable drug:
Suppository:

HEALTH & SAFETY

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

Explain as needed:

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?

Any 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

Explain further details/concerns:

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? ☐☐

Nebraska law requires that kids ages 8-18 must ride secured in a seat belt or booster seat and cannot ride in a cargo area.
It's recommended that kids under 13 ride in the back seat.

Questions / Explain as needed:

Have your testicles ever felt abnormal to you? ☐☐
- Examine your scrotum monthly. Report any changes to the doctor.
-The Gardasil vaccine prevents genital warts (HPV/Human Papilloma Virus) from turning into penile cancer.

Have you ever been abused verbally, physically or sexually? ☐☐
Do you have questions about sexuality? ☐☐

Explain as needed:

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

STUDENT NAME_____ ☐MALE ☐FEMALE

BIRTH DATE_____/_____/_____ **GRADE**_____**AGE**_____

SCHOOL_____ **ACTIVITY**_____

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

STUDENT MEDICAL HISTORY

EVERYONE completes this column.

	Yes	No
1. Have you seen doctor outside of LPG for any reason?	☐	☐
Do you have a recurrent medical or psychological problem?	☐	☐
Has there been a medical illness or injury since last check-up?	☐	☐
Explain yes answers:		
2. Have you ever: --been hospitalized overnight?	☐	☐
Explain yes answers: --had surgery?	☐	☐
3. Are you currently using: --an inhaler?	☐	☐
--prescription or over-the-counter medications/pills?	☐	☐
--supplements or vitamins to gain or lose weight?	☐	☐
Explain yes answers: --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?	☐	☐
Explain yes answers:		
Do you avoid any food groups? Circle: fruit/veg, meat, dairy, fats, carbs, other:	☐	☐
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?	☐	☐
Explain yes answers:		
6. Do you have any current skin problems?	☐	☐
Explain if yes: (itch, rash, acne, warts, fungus or blisters)		
7. Are there allergies to: (circle) pollen, medicine, food, insects?	☐	☐
Does this require medical treatment?	☐	☐
During or after exercise, have you ever developed a rash/hives?	☐	☐
Explain yes answers:		
8. During or after exercise: --do you cough, wheeze, or have trouble breathing?	☐	☐
Explain yes answers: Have you been diagnosed with asthma?	☐	☐
9. During exercise, do you tire more quickly than your friends?	☐	☐
During or after exercise have you ever: -- passed out?	☐	☐
Explain yes answers: --been dizzy?	☐	☐
--had chest pain?	☐	☐
10. Have YOU ever: --been told you have a heart murmur?	☐	☐
Explain yes answers: --had racing of your heart or skipped beats?	☐	☐
--had high blood pressure?	☐	☐
--had elevated cholesterol?	☐	☐

SPORTS PARTICIPANTS complete this box.

	Yes	No
12. 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 the problem here→:

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

13. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position?	☐	☐
Circle: knee brace, neck roll, foot orthotics, teeth retainer or hearing aid		
Other:		
Explain if needed:		
14. Have you had a severe viral infection (ex: myocarditis or mononucleosis) within the past month?	☐	☐
15. Has a physician ever denied or restricted participation in		
Explain yes answers: sports for any heart problems?	☐	☐
16. 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?	☐	☐
17. Do you: --have frequent or severe headaches?	☐	☐
--ever have numbness, tingling in arms, hands, legs, or feet?	☐	☐
Explain yes answers:		
18. Have you ever become ill from exercising in the heat?	☐	☐
19. Do you ever feel stressed out?	☐	☐
Explain yes answers:		

11. Describe relationship to you and details

Has a relative died of heart problems or sudden death before 50?	☐	☐	_____
Has a RELATIVE been diagnosed with: --diabetes?	☐	☐	_____
--severe obesity?	☐	☐	_____
--long Qt Syndrome?	☐	☐	_____
--hypertrophic cardiomyopathy (thick heart)?	☐	☐	_____
--Marfan's Syndrome?	☐	☐	_____

11/18

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.

Signature of student_____ Signature of parent/guardian _____DATE_____