PEDIATRIC HEALTH
ASSESSMENT FORM
15-18 YEARS

CHILD'S NAME: _____ AGE: _____ DATE: _____

PATIENT'S CELL PHONE # (IF ANY): _____ ALLERGIES (MEDICINES, FOODS): _____

MEDICATIONS: _____

MEDICAL PROBLEMS: _____

PRESENT CONCERNS/PROBLEMS: _____

ACCOMPANIED BY: _____ RELATIONSHIP: _____

DAILY LIVING: (FILLED OUT BY PARENT OR GUARDIAN)

DIET: circle which type of MILK- whole, 2%, 1%, skim (HOW MANY CUPS/DAY) _____
OTHER DAIRY (CHEESE, YOGURT) SERVINGS PER DAY _____
MEALS (SERVINGS/DAY) CEREAL/BREAD/GRAIN_____ FRUIT_____ VEGS_____ MEAT/PROTEIN_____
JUICES (CUPS/DAY) _____ OTHER DRINKS (TYPE AND AMOUNT PER DAY)_____
SNACKS(TIMES/DAY) _____ GIVE EXAMPLES OF SNACKS _____
HOW OFTEN DOES YOUR SON/DAUGHTER EAT OUT _____
ANY VITAMINS OR SUPPLEMENTS? _____ IF SO, WHAT KINDS? _____

ANY ACCESS TO WEAPONS?……..	☐ NO	☐ YES
ANY SIBLING RIVALRY?……	☐ NO	☐ YES
ANY STRESSFUL SITUATIONS IN THE HOUSEHOLD? describe briefly below……...	☐ NO	☐ YES
_____		
DO PARENTS OR CAREGIVERS EVER SMOKE?……	☐ NO	☐ YES
ANY EXPOSURE TO ANYONE WITH TB OR WITH HIGH RISK (BORN OR LIVED OUTSIDE THE UNITED STATES, HOMELESS, INCARCERATED, HIV/DRUG USE)? ……	☐ NO	☐ YES
ANY RELATIVES WITH HEART DISEASE OR HIGH CHOLESTEROL BEFORE AGE 55?	☐ NO	☐ YES
HAS THE PATIENT EVER HAD SEX?……..	☐ NO	☐ YES
HAS THE PATIENT EVER USED TOBACCO, ALCOHOL, OR DRUGS?…….	☐ NO	☐ YES
ANY CONCERNS ABOUT VISION OR HEARING?…… ……..	☐ NO	☐ YES
RECENT WEIGHT GAIN OR LOSS?……	☐ NO	☐ YES
IS SEAT BELT USED ALL THE TIME?……	☐ NO	☐ YES
HAVE SMOKE ALARMS?……	☐ NO	☐ YES
FOR GIRLS: HAS BREAST DEVELOPMENT STARTED?……	☐ NO	☐ YES

WHEN WAS FIRST PERIOD? _____ WHEN WAS MOST RECENT OR LAST PERIOD? _____
HOW OFTEN ARE PERIODS? _____ HOW MANY DAYS DOES PERIOD LAST? _____ CRAMPS? (Y / N)
HOW HEAVY ARE PERIODS? HEAVY MEDIUM LIGHT

DESCRIBE AFTER SCHOOL ACTIVITIES _____
WHAT SPORTS DOES HE/SHE PLAY? _____
HOW MUCH EXERCISE PHYSICAL ACTIVITY PER DAY(HOURS/DAY)? _____
MEDIA USE (COMPUTER, VIDEO GAMES, TV, TEXTING, ETC): TYPE AND NUMBER OF HOURS/DAY:
_____
HAS HOUSEHOLD CHORES, IF SO WHAT? _____ HAVE ALLOWANCES?_____

HOW MANY GOOD FRIENDS DOES HE/SHE HAVE? _____
ANY HISTORY OF BULLYING OR ABUSE? _____

HOURS OF SLEEP PER NIGHT_____ ANY SLEEP PROBLEMS OR CONCERNS?_____

WHEN WAS THE LAST DENTAL EXAM? _____

SCHOOL PERFORMANCE: WHAT GRADE IS PATIENT IN? _____ GRADES IN CLASSES? _____
FUTURE PPLLANX AFTER HIGH SCHOOL _____
ANY PROBLEMS IN SCHOOL? _____
ANY PROBLEMS AT HOME BETWEEN PATIENT AND PARENTS OR SIBLINGS? _____
ANY OTHER PERSONALITY OR BEHAVIOR PROBLEMS? _____
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