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? _____
ANY WORK OUTSIDE THE HOME? _____

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 PLANS AFTER HIGH SCHOOL _____
ANY PROBLEMS IN SCHOOL? _____

ANY PROBLEMS AT HOME BETWEEN PATIENT AND PARENTS OR SIBLINGS? _____

ANY OTHER PERSONALITY OR BEHAVIOR PROBLEMS? _____