

**PEDIATRIC HEALTH  
ASSESSMENT FORM  
11 TO 14 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

TOILET HABITS: DRY AT NIGHT? (NO/ YES) HARD STOOLS OR CONSTIPATION? (NO/ YES) SOIL PANTS? (NO/ YES)

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? \_\_\_\_\_

ANY PROBLEMS IN SCHOOL? \_\_\_\_\_

ANY PROBLEMS AT HOME BETWEEN PATIENT AND PARENTS OR SIBLINGS? \_\_\_\_\_

ANY OTHER PERSONALITY OR BEHAVIOR PROBLEMS? \_\_\_\_\_