11-20 Year Health Maintenance Form

(parent to complete)

Patient Name _____

Who accompanied child today? _____
(name and relationship to child)

Who does child live with? _____

Any Chronic health problems? _____

Concerns about the above health problems? _____

New or recent health concerns? _____

Any concerns with child's diet? _____

Does your child take vitamins? Yes No

Does your child or any household member drink from a private well? Yes No
(consider vacation homes, relative's or friend's homes, daycare or school)

Medications:
Please list current medications: _____

_____

_____

Any allergies to medicine? _____

_____

Turn Over Please

If you do not understand any of these questions, please ask your nurse.

Tuberculosis Screening Questionnaire:

Does your child have contact with adults with TB infection?

Yes No

Is child or parent from a region of the world with high prevalence of TB?

Yes No

Is child frequently exposed to immunosuppressed persons, homeless people, nursing home residents, or migrant workers?

Yes No

Does either parent or other individual living in home work in a medically related field or have contact with institutionalized individuals or nursing home residents?

Yes No

Cholesterol Risk Assessment Questionnaire:

Parent or Grandparent with heart disease or stroke under the age of 55? Yes No

Parent or Grandparent with elevated cholesterol >240? Yes No

If you do not understand any of these questions, please ask your nurse.