Northwest PRIMARY CARE

15-17 YEAR
PEDIATRIC DEVELOPMENTAL SCREENING

Date: _____

Name: _____ DOB:_____ Male Female

Physician Signature:_____

Instructions: Please answer the questions below by choosing YES or NO.

General Health		
Do you have any concerns about your health today?	○ NO	○ YES
Do you receive healthcare from anyone besides a medical doctor(acupuncturist, herbalist, naturopath)?	○ NO	○ YES
Nutrition		
Do you eat 5 or more helpings of fruits or vegetables at every day?	○ YES	○ NO
Are your breads, pastas and cereals mostly whole grain?	○ YES	○ NO
Do you eat or drink at least 2-3 servings of calcium rich food per day (beans, green leafy vegetables, milk, yogurt, cheese, calcium-fortified orange juice, soymilk, or cereal)?	○ YES	○ NO
Do you eat more than 1 fast food meal per week?	○ NO	○ YES
Do you eat meals together as a family?	○ YES	○ NO
Do you drink sugary drinks (juice, soda, energy drinks)?	○ NO	○ YES
Do you have concerns or questions about the size or shape of your body?	○ NO	○ YES
In the past year have you tried to control your weight by vomiting, taking diet pills or laxatives or starving yourself?	○ NO	○ YES
Oral Health		
Do you brush your teeth twice a day?	○ YES	○ NO
Do you floss your teeth at least once a day?	○ YES	○ NO
Have you been to the dentist in the last year?	○ YES	○ NO
School		
Are you having problems in school or work?	○ NO	○ YES
Are your grades worse than last year?	○ NO	○ YES
Trouble concentrating?	○ NO	○ YES
Fighting?	○ NO	○ YES
Homework problems?	○ NO	○ YES
Suspension in the last year?	○ NO	○ YES
Missing school or work?	○ NO	○ YES
Activity		
Do you watch TV, play video games, or spend time on the computer more than more than 2 hours per day(not including computer time for homework)?	○ NO	○ YES
Do you have a TV, computer, or video game system in your bedroom?	○ NO	○ YES
Do you participate in any physical activities such as walking, skateboarding, dancing, swimming or playing basketball at least 4 days per week?	○ YES	○ NO
Do you play competitive sports?	○ NO	○ YES
If yes, is there any family history of heart problems or sudden death?	○ NO	○ YES
Injury Prevention		
Do you always wear a seat belt when you are in the car?	○ YES	○ NO

15-17 YEAR PEDIATRIC DEVELOPMENTAL SCREENING

Name: _____ DOB: _____

Injury Prevention		
Do you wear a helmet when you play team sports, in-line skate, skateboard, bicycle, ski, snowboard, or ride a motorcycle, ATV, minibike, or snowmobile	○ YES	○ NO
Do you ever carry a gun?	○ NO	○ YES
Is there a gun in your home?	○ NO	○ YES
Have you started to learn how to drive or do you drive?	○ NO	○ YES
Use a cellphone or headphones while driving?	○ NO	○ YES
Do your text while driving?	○ NO	○ YES
Tuberculosis		
Has a family member or contact had tuberculosis disease?	○ NO	○ YES
Has a family member had a positive TB skin test (PPD)?	○ NO	○ YES
Were you born in a high-risk country (countries other that the U.S., Canada, Australia, or Western Europe?	○ NO	○ YES
Have you traveled to a high-risk country for more than a week?	○ NO	○ YES
Emotional Wellbeing		
Do you worry a lot or feel overly stressed out?	○ NO	○ YES
When you are angry, do you do violent things?	○ NO	○ YES
Do you find yourself continuing to remember or think about an unpleasant experience that happened in the past?	○ NO	○ YES
During the past few weeks have you often felt sad or down, had difficulty sleeping, frequently felt irritable, or felt like you have nothing to look forward to?	○ NO	○ YES
Have you ever seriously thought about killing yourself, made a plan or actually tried to kill yourself?	○ NO	○ YES
Is there someone at home, school, or work that has made you feel afraid, threatened you, or hurt you?	○ NO	○ YES
Even with usual ups and downs, do you enjoy life?	○ YES	○ NO
Do you get along with your family?	○ YES	○ NO
Do you follow your family's rules?	○ YES	○ NO
Review of Systems: *Any **Concerns** about...*		
Eating habits, weight loss, or lack of energy?	○ NO	○ YES
Sleep problems, including excessive snoring?	○ NO	○ YES
Eye redness, excessive tearing, or discharge?	○ NO	○ YES
Recurrent ear, sinus or throat infections, nosebleeds?	○ NO	○ YES
Chest pain, shortness of breath, or irregular heartbeat?	○ NO	○ YES
Frequent colds, cough, wheezing, recurrent lung infections?	○ NO	○ YES
Abdominal pain, vomiting, diarrhea, constipation?	○ NO	○ YES
Kidney or bladder problems, infections, blood in the urine?	○ NO	○ YES
Birthmarks, skin rashes, itching, nail or hair problems?	○ NO	○ YES
Joint pain, stiffness, swelling, muscle pain or weakness?	○ NO	○ YES
Recurrent headaches, dizziness, tics, weakness, seizures?	○ NO	○ YES
Mood changes, sadness, nervous problems?	○ NO	○ YES
Excessive thirst or hunger, increased urination?	○ NO	○ YES
Paleness, anemia, easy bruising, swollen glands?	○ NO	○ YES
Puberty?	○ NO	○ YES
FOR FEMALES:		
Have you gotten your period?	○ YES	○ NO
Problems or questions about menstruation?	○ NO	○ YES
Do you get your periods monthly (21-35 days apart)? Date Last Period:	○ YES	○ NO