WELL CHILD QUESTIONARIE 11 YRS- 20 YRS

Patient Name: _____ **Date of Birth:** _____

Tuberculosis Risk Assessment: **Date:** _____

(Starting at 1 month, 6 months of age and annually thereafter)

1. Has your child been exposed to anyone with a case of TB or a positive tuberculin skin test, or received a tuberculosis vaccination?	Yes	No
2. Was your child, or a household member, born in a high-risk country (countries other than the United States, Canada, Australia, New Zealand, or Western and North European countries)?	Yes	No
3. Has your child travelled (had a contact with resident populations) to a high-risk country for more than 1 week?	Yes	No
4. Does your child have daily contact with adults at high risk for TB (e.g., those who are HIV infected, homeless, incarcerated, and/or illicit drug users)?	Yes	No
5. Does your child have HIV infection?	Yes	No

Anemia Screening:

1. (FEMALES AND MALES) Does the child/adolescent's diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	Yes	No
2. (FEMALES AND MALES) Have you ever been diagnosed with iron deficiency anemia?	Yes	No
3. (FEMALES ONLY) Do you have excessive menstrual bleeding or other blood loss?	Yes	No
4. (FEMALES ONLY) Does your period last more than 5 days?	Yes	No

Heart Disease/Cholesterol Risk Assessment:

1. Is there a family history of parents/grandparents under 55 years of age with a heart attack, heart surgery, angina or sudden cardiac death?	Yes	No
2. Has the child's mother or father been diagnosed with high cholesterol (240 mg/dL or higher)?	Yes	No
Smoking?	Yes	No
Lack of physical activity?	Yes	No
High blood pressure?	Yes	No
High cholesterol?	Yes	No
Diabetes mellitus?	Yes	No

STI/HIV Risk Assessment:

2. If sexually active, have you had more than one partner?	Yes	No
4. Have you ever been sexually molested or physically attacked?	Yes	No
5. Have you ever been diagnosed with any sexually transmitted diseases?	Yes	No
6. Any body tattoos or body piercing of ears, navel, etc., including any performed by friends?	Yes	No
7. Have you had a blood transfusion or are you a Hemophiliac?	Yes	No
8. Any history of IV drug use by you, your sex partner, or your birth mother during pregnancy?	Yes	No