KAISER PERMANENTE®

Well-Care Questionnaire

for preteens aged 10 to 12

WORKSHEET TO BE COMPLETED BY PRETEEN: This worksheet can give your health care team information to help you take better care of yourself. You don't have to answer any questions you don't want to.

Name:

What are your MAIN REASONS for today's visit?

☐ Physical exam ☐ Sports exam ☐ Camp exam ☐ Other concerns, please list:

Family, School, and Other Activities

Who are the people that live with you? (include names, ages, relationships):

Are you in school? ☐ Yes ☐ No
If YES: What grade are you in? Which school do you go to?

What activities or sports do you enjoy?

Are you having a hard time in school? ☐ Yes ☐ No

Do you receive educational services or accommodations at school? (Check all that apply):
☐ IEP ☐ 504 plan ☐ Special education ☐ Other (please describe):

In a typical month, how often do you miss a class or day of school (number of days)? _____

Medications

What medicine are you taking, including prescription, herbal, and over-the-counter?

Medical History – check box if you have, or ever had, any of the following:

☐ Asthma	☐ Developmental concerns	☐ Stomach or gastrointestinal problems
☐ Behavioral problems	☐ Seizure/Epilepsy	☐ Heart problems
☐ Learning disability /ADD	☐ Surgeries	☐ Chickenpox If yes, how old were you?
☐ Allergies	☐ Diabetes	

List other major illnesses, operations, hospitalizations, injuries, or conditions (describe and give year):

Family History

Check this box if you know you were adopted: ☐

Please check boxes below if you have any family members who have had any of following:

☐ Alcohol/drug problems ☐ Asthma/allergies ☐ Cancer ☐ Depression/suicide ☐ Diabetes ☐ Other illnesses/conditions	Which family members? _____ _____ _____ _____ _____

Sports

Have you ever:

Passed out or nearly passed out while exercising?	☐ Yes ☐ No
Had discomfort, pain, tightness or pressure in chest while exercising?	☐ Yes ☐ No
Had your heart race or skip beats while exercising?	☐ Yes ☐ No
Felt lightheaded while exercising?	☐ Yes ☐ No
Had an unexplained seizure?	☐ Yes ☐ No
Been more tired or short of breath than your friends while exercising?	☐ Yes ☐ No
Had heart problems?	☐ Yes ☐ No
Been knocked out or had a concussion?	☐ Yes ☐ No
Broken a bone, or had a dislocation or other significant sports injury?	☐ Yes ☐ No

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Do you have any of the following:	
Family member who died suddenly before the age of 50?	☐Yes ☐No
Family history of heart problems?	☐Yes ☐No
Family history of unexplained fainting, seizures, drowning, or near drowning?	☐Yes ☐No
Nutrition	
Do you eat fruits and vegetables every day?	☐Yes ☐No
Do you eat or drink dairy products?	☐Yes ☐No
Are you a vegetarian?	☐Yes ☐No
Do you have any questions or concerns about your eating habits?	☐Yes ☐No
Safety	
Do you always wear a helmet when you're on a bicycle, skateboard, or ATV?	☐Yes ☐No
Do you always use your seat belt when in a car or truck?	☐Yes ☐No
Do you ever ride with a driver who has used alcohol or drugs, or who seemed drunk or high to you?	☐Yes ☐No
Do you or any of your friends have access to guns?	☐Yes ☐No
If yes, are they stored unloaded and locked?	☐Yes ☐No ☐ I don't know
Has anyone ever touched you in a way that made you uncomfortable or afraid?	☐Yes ☐No
Family and Peers	
Do you get along with your family?	☐Yes ☐No
Are you having a hard time at home?	☐Yes ☐No
Do you have a friend you can talk to about problems you have?	☐Yes ☐No
Are you having a hard time with friends?	☐Yes ☐No
Are you having trouble with fighting or bullying?	☐Yes ☐No
Are you feeling pressure to do what others are doing?	☐Yes ☐No
Stress and Depression	
During the past 2 years, have you or anyone in your family had any major good or bad changes?	☐Yes ☐No
Do you have any concerns about your body or weight?	☐Yes ☐No
Do you ever eat in secret or feel guilty about eating?	☐Yes ☐No
Do you ever make yourself throw up?	☐Yes ☐No
In the last 2 weeks: Have you recently lost interest or pleasure in doing things?	☐Yes ☐No
In the last 2 weeks: Have you been feeling down, depressed, irritable, or hopeless?	☐Yes ☐No
Tobacco, Alcohol, Marijuana and Other Drugs	
Are you around people who smoke?	☐Yes ☐No
Have you ever used tobacco or nicotine products (cigarettes, chew, e-cigarettes, vaping device)?	☐Yes ☐No
During the past 12 months:	
Did you drink any alcohol (more than a few sips, do not count sips taken during family/religious events)?	☐Yes ☐No
Use any marijuana (weed) or hashish?	☐Yes ☐No
Use anything else to get high (ie: illegal drugs, over the counter and prescription drugs, things you sniff or huff)?	☐Yes ☐No
Have you ever ridden in a car driven by someone (including yourself) who was high or had used alcohol or drugs?	☐Yes ☐No
Sexuality	
Do you have any questions about puberty or any of the changes happening to your body?	☐Yes ☐No
Have you talked about sex with an adult in your family?	☐Yes ☐No
Do you have any questions about masturbation?	☐Yes ☐No
For Females	
Have your periods started?	☐Yes ☐No
If YES, how old were you when they started? _____ Are they regular?	☐Yes ☐No
Do menstrual cramps keep you from doing your normal activities?	☐Yes ☐No

DO NOT FILE IN MEDICAL RECORD