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?	**For clinic use**
☐ Physical exam ☐ Sports exam ☐ Camp exam ☐ Other concerns, please list:	**Chief Complaint**

Family, School, and Other Activities

Who are the people that live with you? (include names, ages, relationships):	**History: Social Documentation Flow Staff Note**
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	**Provider Note**
In a typical month, how often does your child miss a class or day of school (number of days)? _____	**Provider Note**

Medications

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

Medical History: Check box if you have, or ever had, any of the following?

☐ Asthma	☐ Developmental concerns	☐ Stomach or gastrointestinal problems	**History: Medical/Surgical**
☐ 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 here if you know you were adopted ☐	**History: Family**
Please check boxes below if you have any family members who have had any of following: Which family members? ☐ Depression/suicide _____ ☐ Diabetes _____ ☐ Alcohol/drug problems _____ ☐ Asthma/allergies _____ ☐ Other illnesses/conditions _____	

Sports

Have you ever:		
Passed out while exercising?	☐ **Yes** ☐ No	**Provider Note**
Gotten dizzy or had headaches while exercising?	☐ **Yes** ☐ No	
Been knocked out?	☐ **Yes** ☐ No	
Had a significant joint or bone problem?	☐ **Yes** ☐ No	
Had a serious injury?	☐ **Yes** ☐ No	
Can you run for 10 minutes without stopping?	☐ Yes ☐ **No**	
Do you have a family member with heart disease?	☐ **Yes** ☐ No	
Do you have a family member who died suddenly before the age of 50?	☐ **Yes** ☐ No	

NOT TO BE FILED IN THE MEDICAL RECORD

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Nutrition		
Do you eat fruits and vegetables every day?	☐Yes ☐**No**	**Provider Note**
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**	**Provider Note**
Do you always use your seat belt when in a car or truck?	☐Yes ☐**No**	
Do you ever ride with a driver who had alcohol or drugs?	☐**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** ☐**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**	**Provider Note**
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	**Provider Note**
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	
Have you recently lost interest or pleasure in doing things?	☐**Yes** ☐No	**If YES to either of the last 2 questions, complete PHQ-9 depression workflow**
Have you been feeling down, depressed, irritable, or hopeless?	☐**Yes** ☐No	
Tobacco, Alcohol, Marijuana and Other Drugs		
Have you ever used tobacco (smoke, chew, e-cigarettes) or other vapor product?	☐**Yes** ☐No	**Provider/Social: Substance & Sexuality**
Are you around people who smoke?	☐**Yes** ☐No	
Do you drink alcohol?	☐**Yes** ☐No	
Do you do anything to get high, such as huffing, sniffing, smoking marijuana or using any other drugs?	☐**Yes** ☐No	
Sexuality		
Do you have any questions about puberty or any of the changes happening to your body?	☐Yes ☐No	**Provider Note**
Have you talked about sex with an adult in your family?	☐Yes ☐No	**Provider/Social: Substance & Sexuality**
Do you have any questions about masturbation?	☐Yes ☐No	
For Females		
Have your periods started?	☐Yes ☐No	**Provider Note**
If YES, how old were you when they started?		
Do menstrual cramps keep you from doing your normal activities?	☐Yes ☐No	

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