OBERLIN ROAD PEDIATRICS

PATIENT

Well Child Check: School Aged Child (13-14 years)

Your Name: _____

Do you have any concerns, questions, or problems that you would like to discuss today? If yes, please describe:

_____

_____

Current grade/name of school _____

Nutrition:

Do you get 4 servings of dairy a day? □ Yes □No

What milk do you drink? _____

Does your diet include iron-rich foods daily (meat, beans, enriched cereals/cheerios)? □ Yes □ No

Do you eat a vegetarian diet (do not eat red meat, chicken, fish, or seafood)? □ No □ Yes

If you are a vegetarian, do you take an iron supplement? □ Yes □ No

Females:

If you have started your menstrual cycle, do you think you have excessive menstrual bleeding? □ No □ Yes □ N/A

Dental Health:

Do you brush your teeth 2x per day? □ Yes □ No

CARDIOVASCULAR SCREEN:

Have you ever fainted while exercising?	No	Yes
Do you typically cough or have shortness of breath when exercising? Outside of deconditioning?	No	Yes
Have you gotten aching chest pain when you exercise?	No	Yes
Has anyone in your family had a heart attack or stroke before age 55?	No	Yes
Did anyone in the family die suddenly while exercising?	No	Yes

MENTAL HEALTH SCREEN (PHQ-2)

In the past two weeks, how often have you been bothered by the following symptoms:

1. Feeling down, depressed, irritable, or hopeless?
   Not at all Several Days More than half of the time Nearly every day

2. Little interest or pleasure in doing things?
   Not at all Several Days More than half of the time Nearly every day

Who lives with you at home? _____
Are parents: single married divorced separated
What things do you like to do?

_____

_____

Are you doing well at school?	□ Yes	□ No
Do you have things you enjoy doing at school?	□ Yes	□ No
Do you get extra help or support in any subjects at school?	□ No	□ Yes
Do you have any concerns about your weight?	□ No	□ Yes
Are you currently doing anything to try to gain or lose weight?	□ No	□ Yes
Do you eat fruit and vegetables every day?	□ Yes	□ No
Do you drink sugar sweetened beverages (juice, soda, sports drinks)?	□ No	□ Yes
Do you ever skip meals?	□ No	□ Yes
Do you eat meals together with your family?	□ Yes	□ No
Are you physically active at least 1 hour a day?	□ Yes	□ No
How much time everyday do you spend watching TV, playing video games, or using computers, tablets or smartphones (not counting schoolwork)?	_____	
Do you get 8 or more hours of sleep each night?	□ Yes	□ No
Do you have trouble sleeping?	□ No	□ Yes
Females: Do you have any concerns about your period (such as not regular, heavy bleeding or bad cramping)?	□ No	□ Yes
Do you smoke cigarettes, vape, chew tobacco?	□ No	□ Yes
Does anyone in your home smoke or vape?	□ No	□ Yes
Do you drink alcohol?	□ No	□ Yes
Have you ever used drugs (including marijuana or street drugs)?	□ No	□ Yes
Do you spend time talking with your parents every day?	□ Yes	□ No
Do you get along with your family?	□ Yes	□ No
Does your family do things together?	□ Yes	□ No
Do you have an adult you feel connected to?	□ Yes	□ No
Do you have rules at home and know what happens when you break the rules?	□ Yes	□ No
Have you ever taken prescription drugs that were not given to you for a medical condition?	□ No	□ Yes
Do you always wear a lap and shoulder seat belt?	□ Yes	□ No
Do you always wear a helmet to protect your head when you are biking, skateboarding, or skating?	□ Yes	□ No
Do you use sunscreen?	□ Yes	□ No
Do you visit tanning parlors?	□ No	□ Yes
Do you have activities or things you like to do after school or on the weekend?	□ Yes	□ No
Do you feel safe at home?	□ Yes	□ No
Have you ever been bullied in person, on the internet, or through social media?	□ No	□ Yes
Have you been in a relationship with a person who threatened you physically or hurt you?	□ No	□ Yes
Have you ever been forced or pressured to do something sexually that you didn't want to do?	□ No	□ Yes