WENTWORTH HEALTH PARTNERS

YOUTH HEALTH QUESTIONNAIRE

Name:_____ **DOB:**_____ **AGE:**_____ **Sex:** ☐M ☐F

CURRENT MEDICATIONS (may bring own list to visit if you prefer)

Name of Medication	Strength of Medication	Dosing Instructions

* Note – this information may be taken directly from the pharmacy label on prescription products

ALLERGIES

☐ No Known Allergies ☐ Medication Allergies ☐ Environmental/Seasonal Allergies ☐ Latex Allergy

Please specify Allergen *AND* Reaction below:

_____

_____

_____

PAST MEDICAL HISTORY

Please list medical history for this patient and if possible indicate the age at diagnosis for each condition.

☐ Allergies ☐ Asthma ☐ ADD/ ADHD ☐ Congenital Defect ☐ Mood/Behavior Disorder

☐ Other _____

_____

_____

PAST SURGICAL HISTORY

Please list surgical history and hospitalizations for this patient and if possible list the age or year when surgery (or hospitalization) was performed.

Date of Surgery or Hospitalization	Age or Year	Surgery (Operation) or Reason for Hospitalization

FAMILY HISTORY (Check all that apply)

☐ Allergies ☐ Anemia ☐ Asthma ☐ Cancer (specify) _____

☐ Diabetes ☐ Epilepsy/Seizure Disorder ☐ Heart Disease

☐ High Blood Pressure ☐ High Cholesterol ☐ Mental Illness

☐ Other (please list) - _____

We would like to personally thank you for taking the time to complete this form. Doing so provides us with the information necessary to make the most out of each and every healthcare visit together.

SOCIAL HISTORY

Family Information

Mother's Name: _____ Mother's Occupation: _____

Father's Name: _____ Father's Occupation: _____

Siblings: ☐ Yes ☐ No Sibling Names and Ages_____

Guardian Name and Relationship (if applicable):_____

If parents live separately, where is the child's primary residence?_____

Who lives at home? _____

Are there pets in the home? ☐ Yes ☐ No If yes, specify type and name _____

Does anyone in the home smoke? ☐ Yes ☐ No_____

Child Care and Education

Does this child attend child care? ☐ Yes ☐ No

If yes, what is the name of the child care center? If yes, how many hours per week?

_____ _____

Does this child attend school? ☐ Yes ☐ No

If yes, what is the name of the school? If yes, what grade?

_____ _____

Do you have concerns about your child's adjustment or performance in school? ☐ Yes ☐ No

If yes, please explain: _____

_____

Learning Needs

Is your primary language English? ☐ Yes ☐ No If no, please note primary language: _____

How would you like health information about your child/youth presented?

☐ 1:1 Conversations with health care provider ☐ Reading Materials ☐ Classroom

Who makes up your household? (check all that apply):

☐ Single Parent ☐ Two parent household ☐ Siblings ☐ Others, not family

Interests/Hobbies/Recreational Activities

_____

_____

Tobacco Exposure (check all that apply)

☐ Patient is a Smoker ☐ Smokers in Home ☐ Smoke outside only

Activity (check all that apply)

☐ Exercise/Sports (Hours per day)_____ ☐ TV/Computer Games (Hours per day)_____

☐ Internet (Hours per day)_____ ☐ Text Messaging (Hours per day)_____

Sleep (check all that apply)

☐ Takes Naps ☐ Sleeps with Parents ☐ Sleeps through the night ☐ Minimum 8 hours nightly ☐ Nightmare/sleep problems

Safety (check all that apply)

☐ Uses bike helmet ☐ Car Seat Rear Facing ☐ Car Seat Front Facing ☐ Booster ☐ Seat Belt ☐ Carbon Monoxide Detector

☐ Smoke Detectors ☐ Radon Detectors ☐ Fire Arms in Home ☐ Pool/Spa ☐ Pet/Animals Type & Number_____

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CONCERNS

Please list any concerns you have regarding the health of this child in the space provided.

_____

_____

_____

_____

_____

Name and Relationship of Person Completing Form (print): _____

Signature: _____ **Date:** _____

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