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Patient's Name: _____ Date: _____

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Vickery Pediatrics Adolescent Questionnaire/Laboratory Consent

Vickery Pediatrics strives to provide the best possible medical care to our patients. In conjunction with **AAP recommendations**, we have compiled a questionnaire to address common adolescent concerns and problems. This questionnaire is adapted from the ***AAP, Bright Futures Guidelines for Health Supervision***. It will be provided separately to your adolescent for completion. Among other things, there are questions related to healthy choices, substance use and sexual activity. What we discuss is confidential, but we always encourage our patients to be open with their families as they are their best support network.

We also wanted to let you know the latest AAP guidelines regarding sexual activity:

1. **If your child is 11+ years old and sexually active** – recommendation is to obtain a urine sample to check for Gonorrhea and Chlamydia.
2. **If your child is between the ages of 16 and 18** – HIV screening is recommended regardless of sexual activity
3. **If your female child is 21 years old** – PAP smear is recommended

Please Mark Your Preferences Below:

___ Yes ___ No I would like labs drawn/sent following the above recommendations.

___ Yes ___ No I give permission for my child to speak with his/her provider at Vickery Pediatrics privately and confidentially.

Parent signature _____ Date_____

Witness _____ Date_____

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TB Exposure Assessment

Respond to the following questions:	Yes*	No
1. Has your child traveled to Eastern Europe, Asia, Africa, Central or South American since last WCC for period > 1 week?	◯	◯
2. Does your child have frequent hospital visits?	◯	◯
3. Does your child have frequent prison visits?	◯	◯
4. Does your child have frequented homeless shelter visits?	◯	◯
5. Does your child have frequent nursing home visits?	◯	◯
6. Does your child have contact with someone infected with TB?	◯	◯
7. Does your child have or come in contact with a person who has HIV?	◯	◯
8. Was your child born outside the US?	◯	◯
9. Does your child have contact with drug users or migrant workers?	◯	◯
10. Does your child have a known immune disorder?	◯	◯

if yes, your child may need a PPD placed or IGRA blood test performed to rule out infection with Tuberculosis*

Cholesterol Assessment

FAMILY HISTORY	Yes*	No
1. Is there a parent/grandparent/Aunt or Uncle/sibling with history of cardiac attack, treated angina, CABG/stent/angioplasty, stroke, sudden cardiac death in Male </= 55 yrs. or female </= 65 yrs.?	◯	◯
2. Does a parent have Total cholesterol >240 mg/dL or history of dyslipidemia?	◯	◯

PATIENT'S PERSONAL HISTORY	Yes*	No
3. Does patient have a history of Diabetes, High BP, BMI >/= 85% or use tobacco?	◯	◯
4. Does patient have chronic kidney disease, kidney or heart transplant, Kawasaki's disease, autoimmune illness, HIV, or nephrotic syndrome?	◯	◯

If yes, then your child may need a fasting lipid panel drawn (if not done previously) or if prior results were abnormal*

___YES ___ NO** Do you use **Fluoridated** water (treated tap (city/county), filtered through refrigerator, or bottled water?

___YES ___ NO** Has your child seen a dentist in the past 6 – 12 months?

___YES** ___ NO Do you have concerns about your child's eyes or their ability to see?

___YES** ___ NO Do you have any concerns about your child's ability to hear?

___YES ___ NO** Does your child's diet contain Iron-rich foods such as meat, eggs, iron-fortified cereal and beans?

VICKERY PEDIATRICS ADOLESCENT QUESTIONNAIRE

Patient response may require referral to a specialist or further evaluation/treatment recommendations. *

Patient _____ **Date** _____

Do you want to speak privately to the doctor? YES NO

QUESTIONS ABOUT YOUR FAMILY

no lives at home with you?	Parent(s)/Guardian and siblings, Other_____	Parents divorced and both live in Ga	Parents divorced and live in different states
ve there been any major changes in your mily's life recently?	No	Yes* – please explain	
you and your parents argue a lot about what ur culture expects of you and what your ends are doing?	No	Yes*- please explain	
you feel safe in your current living situation?	Yes	No* - please explain	
you have at least one adult in your life who u know you can got to if you need help	Yes	No* – please explain	

QUESTIONS ABOUT YOURSELF

ENERAL		
you do things that help you have a healthy lifestyle, such eating healthy foods, being physically active and keep urself safe?	Yes	No*- please explain
e you becoming more independent and making more of ur own decisions?	Yes	No
you feel hopeful and confident?	Yes	No
e you able to bounce back when life doesn't go your y?	Yes	No
e there any issues with your hearing, vision or completing eryday tasks?	No	Yes* – please explain

you have any concerns with your body image and how ur body is changing?	No	Yes* – please explain
you have any concerns or questions with performance at hool?	No	Yes* – please explain
you feel really stressed out all the time?	No	Yes* – Do you have strategies to reduce or relieve your stress?

TERPERSONAL VIOLENCE		
ve you ever been bullied in person, online, or through cial media?	No	Yes*- when?
ve you ever been in a fight in the past 6 months?	No	Yes
ve you been a part of or are currently in a gang?	No	Yes
ve you ever been physically hurt (including hitting or pping) while on a date or in a relationship?	No	Yes* – please explain
ve you ever been touched in a sexual manner without nsent or forced into sexual intercourse?	No	Yes* – please explain
you or have you ever harmed yourself such as by tting, hitting, or pinching yourself?	No	Yes* - please explain

LCOHOL & DRUG USE **** This response may require referral to a specialist or further evaluation/treatment recommendations. ****		
you live with anyone or spend time in places where ople smoke cigarettes or vape?	No	Yes* – please explain
there anyone in your life whose tobacco, alcohol or g use that concerns you?	No	Yes*- please explain

ring the past 12 months – did **you** drink more than a few s of alcohol?	No	Yes* – how much?
you smoke or use any tobacco, marijuana, hashish or pe products?	No	Yes* – please explain
you use anything else to get high?	No	Yes* – what?

EXUAL HEALTH				
ve you **ever** had sex, including intercourse or oral sex?	No	Yes- what method of contraception do you use?		
you identify yourself as male, female or non-binary rcle the one that applies)	Male	Female	Non-binary	Other
you have questions about your own sexuality or gender ntity?	No	Yes* – please explain		

EMALES ONLY			
w old were you when you had your 1st enstrual period?	Age_____ (answer next 2 boxes) N/A_____ (Skip the next 2 boxes)	Are they regular? Yes___ No____	Any bleeding > 7 days or cycles more often than 25 – 35 days in frequency Yes ____ No ____

PHQ-4

er the last 2 weeks, how often have youbeen bothered by the following blems? *e "✔" to indicate your answer)*	Not at all	Several	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Little interest or pleasure in doing things	0	1	2	3
4. Feeling down, depressed, or hopeless	0	1	2	3

(*For office coding: Total Score* =_____)

**** This response may require referral to a specialist or further evaluation/treatment recommendations. ****