Bryan CRETE AREA MEDICAL CENTER

Health Maintenance Questionnaire
11-14 YEAR

(student to complete)

Patient Name _____

What School do you attend? _____

What grade are you in/entering? _____

How are your grades in school? (circle all that apply) As Bs Cs Ds Fs

How often do you miss school? (circle one) Rarely or never
1-2 time per semester
once a month or more

What activities/sports/clubs are you involved in? _____

What do you do in your free time? _____

How often do you exercise? (circle one) Daily
3-4 times per week
1-2 times per week
less than once per week

How many hours do you sleep at night, on average?_____

Do you wear contacts or glasses? (circle one) No Contacts Glasses

Do you wear your seat belt? Yes No

Are you concerned about your weight? Yes No

Are you doing anything to change your weight? Yes No

If so what? _____

Do your friends smoke, drink alcohol or use drugs? Yes No

If you do not understand any of these questions, please ask your nurse.

Have you ever tried smoking? Yes No

Have you tried illegal drugs? Yes No

Have you ever tried alcohol? Yes No

Have you ever talked to your parents/guardians about dating and sex? Yes No

Do you have questions about your changing body? Yes No

Do you ever feel unsafe at home or at school? Yes No

Do you ever have thoughts about hurting yourself or that life isn't worth living?

Yes No

Who do you usually talk to when you have a problem or concern?

_____

Have you ever fainted? Yes No

Have you ever fainted during exercise? Yes No

Have you had chest pain during exercise? Yes No

Has anyone in your family died suddenly? Yes No

Before age 35? Yes No

Before age 50? Yes No

If "yes" to either of the above, cause of death? _____

Have you ever had a concussion, loss of consciousness, been knocked out or had a head injury? Yes No

If yes how many times? _____

Have you ever had heat stroke or heat exhaustion? Yes No

Do you wheeze or cough during or after exercise? Yes No

Do you have, or have you ever had asthma? Yes No

Do you have any questions or concerns that you would like to discuss? Yes No

Females: At what age did you start your periods? _____

Have you had any problems with your periods? Yes No

If you do not understand any of these questions, please ask your nurse.