Sutter Health

Parent Questionnaire for Adolescent Health Care Visit

Your Child's Name: _____

Please take a moment to answer the following questions about your child and your family. Your answers are confidential. If you choose not to answer any question, just leave blank.

Do you have any concerns about the following:			
Nutrition, weight, or level of physical activity?	Yes	No	Unsure
About how your family gets along?	Yes	No	Unsure
Puberty, sexuality or gender?	Yes	No	Unsure
Ability to learn or performance at school?	Yes	No	Unsure
Mood or behavior?	Yes	No	Unsure
Friends may be using alcohol, tobacco, or other drugs?	Yes	No	Unsure
Child's friends?	Yes	No	Unsure

Risk Assessment for Tuberculosis Exposure/Infection:			
Has a family member or contact had tuberculosis disease?	Yes	No	Unsure
Since your child's last well check has a family member or contact had a positive tuberculosis test?	Yes	No	Unsure
Was your child born in a high-risk country (Countries other than the United States, Canada, Australia, New Zealand, or western European countries)?	Yes	No	Unsure
Has your child traveled to (or had contact with people who live in) a high-risk country for more than one week (Countries other than the United States, Canada, Australia, New Zealand, or western European countries)?	Yes	No	Unsure

Risk Assessment for Abnormal Lipid Profile (such as high cholesterol):			
Did any of your child's parents or grandparents have significant heart disease at or before 55 years of age (had a heart attack, stroke, angioplasty, angina, or bypass surgery)?	Yes	No	Unsure
Do either of the child's parents have a cholesterol level of 240 or higher? (Cholesterol screening may also be considered in anyone who is overweight, doesn't get much exercise, or who has high blood pressure or diabetes.)	Yes	No	Unsure
Do you have any concerns about your child's development, or any other concerns you would like to discuss with your provider? If so, please describe?	Yes	No	

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May 2015