

DAKOTA PEDIATRIC CLINIC



Health Supervision: 17-20 Years

Patient Name: _____ Date: _____

To provide good preventative health care for your child, we would like to you answer these questions. It will help us focus on areas of possible concern. Your responses will be respected and kept confidential. Please feel free to add information or comments.

1. What questions or concerns do you have today?

2. Have there been any unexpected stresses, or family changes since your last visit?
List:

3. Has your teen seen the dentist in the past year? Y N

4. How is your teen doing in school? Top Middle Bottom
Are there any behavior or attendance problems at school? Y N

5. Does your teen have close friends? Y N
Do you feel comfortable with your teen's friends? Y N
Do any of your teen's friends use drugs, alcohol, or smoke? Y N

6. How many hours does your teen sleep? _____
Does he/she seem rested when he/she wakes up? Y N

7. Has your teen had any injuries since the last visit? Y N

8. Does anyone in your immediate family smoke? Y N
Does your teen smoke? Y N

9. Do you have any concerns about your teen's height, weight
or sexual development? Y N

10. Do you feel you or your teen needs help with discipline? Y N

11. Does your teen have a TV, VCR, game machine, or computer
in his/her room? Y N

12. Does your teen spend more than 2 hours a day with the
TV, video games, or computer? Y N

13. Does your teen have access to on-line computer services? Y N

14. Have you discussed the risks of inappropriate sexual or violent
material, potential child molesters or harassment on the internet? Y N

15. Does your teen know not to give personal information via the
internet? Y N

OVER

16. Does your teen eat:

Fruits	rarely	sometimes	daily
Vegetables	rarely	sometimes	daily
Meats	rarely	sometimes	daily
Dairy	rarely	sometimes	daily
Milk	Y	N	How many oz's of milk each day? _____

17. Do you enforce the use of helmets for:	riding a bike	Y	N	NA
	riding a scooter	Y	N	NA
	riding an ATV	Y	N	NA
	riding a motorcycle	Y	N	NA
	rollerblading	Y	N	NA
	skateboarding	Y	N	NA

18. Does your teen always wear a seatbelt in the car? Y N

19. If there is a gun in your home, is the gun locked up? Y N

If the ammunition locked separately? Y N

20. Does your teen feel safe in school, at home, in your neighborhood? Y N

21. Do you have smoke and carbon monoxide alarms in your house? Y N

22. Does your teen often feel stressed, anxious, or angry? Y N

23. Does your teen often feel depressed, sad or alone? Y N

24. Does your teen gamble? Y N

25. Has your teen been in trouble at school or with the law? Y N

Family History: Are you aware of any family members with the following history?

Please indicate which family members.

Y	N	Abuse/violence
Y	N	Allergy/asthma
Y	N	Attention deficit
Y	N	Arthritis
Y	N	Cancer
Y	N	Stroke
Y	N	Chemical dependency
Y	N	Diabetes
Y	N	Depression
Y	N	Drinking problem or alcoholism

Y	N	Drug addiction
Y	N	Elevated cholesterol
Y	N	High blood pressure
Y	N	Heart disease
Y	N	Kidney disease
Y	N	Learning problems
Y	N	Migraine headaches
Y	N	Obesity
Y	N	Seizures
Y	N	Other:

Parent/Guardian: _____