**Well-Care Questionnaire for preteens aged 10 to 12**

**WORKSHEET TO BE COMPLETED BY PRETEEN:** This worksheet can give your health care team information to help you take better care of yourself. You don’t have to answer any questions you don’t want to.

### Name:

### What are your MAIN REASONS for today’s visit?

- • Physical exam  
- • Sports exam  
- • Camp exam  
- • Other concerns, please list:  

  **For clinic use**

  **Chief Complaint**

### Family, School, and Other Activities

- Who are the people that live with you? (include names, ages, relationships):

  **History:**  
  **Social Documentation**  
  **Flow Staff Note**

- Are you in school?  
  - • Yes  
  - • No

  **Provider Note**

  **Provider Note**

- If YES: What grade are you in?  
- Which school do you go to?

### Medications

- What medicine are you taking, including prescription, herbal, and over-the-counter?

  **Medications**

### Medical History – check box if you have, or ever had, any of the following:

- • Asthma
- • Developmental concerns
- • Stomach or gastrointestinal problems
- • Behavioral problems
- • Seizure/Epilepsy
- • Heart problems
- • Learning disability /ADD
- • Surgeries
- • Chickenpox  
  - If yes, how old were you?
- • Allergies
- • Diabetes

  **List other major illnesses, operations, hospitalizations, injuries, or conditions (describe and give year):**

  **Medications**

### Family History

- Check this box if you know you were adopted:  

  **History:**  
  **Medical/Surgical**  
  **Family**

- Please check boxes below if you have any family members who have had any of following:

  Which family members?

  - • Depression/suicide
  - • Diabetes
  - • Alcohol/drug problems
  - • Asthma/allergies
  - • Other illnesses/conditions

### Sports

- Have you ever:

  - • Passed out or nearly passed out while exercising?  
  - • Had discomfort, pain, tightness or pressure in chest while exercising?  
  - • Had your heart race or skip beats while exercising?  
  - • Felt lightheaded or shorter of breath than expected while exercising?  
  - • Had an explained seizure?  
  - • Been more tired or short of breath than your friends while exercising?  
  - • Had heart problems?  
  - • Been knocked out or had a concussion?  
  - • Broke a bone, or had a dislocation or other significant sports injury?

### Do you have any of the following:

- • Family member who died suddenly before the age of 50?  
- • Family history of heart problems?  
- • Family history of unexplained fainting, seizures, or near drowning?

**DO NOT FILE IN MEDICAL RECORD**

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## Nutrition
- Do you eat fruits and vegetables every day? [ ] Yes [ ] No
- Do you eat or drink dairy products? [ ] Yes [ ] No
- Are you a vegetarian? [ ] Yes [ ] No
- Do you have any questions or concerns about your eating habits? [ ] Yes [ ] No

## Safety
- Do you always wear a helmet when you’re on a bicycle, skateboard, or ATV? [ ] Yes [ ] No
- Do you always use your seat belt when in a car or truck? [ ] Yes [ ] No
- Do you ever ride with a driver who had alcohol or drugs? [ ] Yes [ ] No
- Do you or any of your friends have access to guns? [ ] Yes [ ] No
  - If yes, are they stored unloaded and locked? [ ] Yes [ ] No [ ] Don’t know
- Has anyone ever touched you in a way that made you uncomfortable or afraid? [ ] Yes [ ] No

## Family and Peers
- Do you get along with your family? [ ] Yes [ ] No
- Are you having a hard time at home? [ ] Yes [ ] No
- Do you have a friend you can talk to about problems you have? [ ] Yes [ ] No
- Are you having a hard time with friends? [ ] Yes [ ] No
- Are you having trouble with fighting or bullying? [ ] Yes [ ] No
- Are you feeling pressure to do what others are doing? [ ] Yes [ ] No

## Stress and Depression
- During the past 2 years, have you or anyone in your family had any major good or bad changes? [ ] Yes [ ] No
- Do you have any concerns about your body or weight? [ ] Yes [ ] No
- Do you ever eat in secret or feel guilty about eating? [ ] Yes [ ] No
- Do you ever make yourself throw up? [ ] Yes [ ] No
  - Have you recently lost interest or pleasure in doing things? [ ] Yes [ ] No
  - Have you been feeling down, depressed, irritable, or hopeless? [ ] Yes [ ] No

## Tobacco, Alcohol, Marijuana and Other Drugs
- Have you ever used tobacco (smoke, chew, e-cigarettes) or other vapor product? [ ] Yes [ ] No
- Are you around people who smoke? [ ] Yes [ ] No
- Do you drink alcohol? [ ] Yes [ ] No
- Do you do anything to get high, such as huffing, sniffing, smoking marijuana or using any other drugs? [ ] Yes [ ] No

## Sexuality
- Do you have any questions about puberty or any of the changes happening to your body? [ ] Yes [ ] No
- Have you talked about sex with an adult in your family? [ ] Yes [ ] No
- Do you have any questions about masturbation? [ ] Yes [ ] No

## For Females
- Have your periods started? [ ] Yes [ ] No
  - If YES, how old were you when they started? [ ]
- Do menstrual cramps keep you from doing your normal activities? [ ] Yes [ ] No

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