

Name _____

Birth Date _____

Please fill out the following questionnaire. It will allow the provider to focus on your main concerns during the visit, and allow more time for discussion.

Review of Nutrition & Exercise

	Yes	No
Do you eat well-balanced diet, including fruits, vegetables, milk, and vitamins?	()	()
Do you see a dentist twice a year?	()	()
Do you brush her/his teeth 2 times daily and floss daily?	()	()
Do you get 60 minutes of physical activity per day?	()	()
Do you limit screen time (TV, video games, computer) limited to <2 hours per day?	()	()
Are you satisfied with your current weight?	()	()
Is your family free of heart attacks and strokes in people younger than 55?	()	()

Elimination

	Yes	No
Are your bowel movements regular and comfortable?	()	()

Sleep

	Yes	No
Do you sleep well, without snoring often?	()	()
Are you well-rested during the day?	()	()

Menstrual Cycle

	Yes	No
Have your periods started yet? If so, when? _____	()	()
If so, are they regular and causing minimal pain?	()	()
Do they last 5 or less days most of the time?	()	()

Tuberculosis (TB) risk?

	Yes	No
Have you had contact with a person who has tuberculosis?	()	()
Are you immuno-suppressed (HIV, cancer, chronic steroids)?	()	()
Birth or travel to endemic Tuberculosis areas (Africa, Asia, Latin America, Caribbean)	()	()
Regular contact with adults at high risk for TB (Homeless, Jailed, Illegal drug user, HIV positive person, migrant farm worker, nursing home resident)	()	()

Have you had any significant illnesses since the last time we saw you? If yes, please describe:

Are there any new stresses on your family since the last time we saw you? If yes, please describe:

Current concerns not listed above:
