OBERLIN ROAD PEDIATRICS

PARENT/GUARDIAN

Well Child Check: School Aged Child (13-14 years)

Your Child's Name: _____

Do you have any concerns about your teen's behavior, learning, or development? If yes, please describe:

_____

_____

Does your teen take any medications or supplements, including vitamins?	□ No	□ Yes: _____
Does your teen have known allergies to foods/medicines?	□ No	□ Yes: _____
Does your teen see any specialists outside of Oberlin?	□ No	□ Yes: _____

What things delight you the most about your teen?

_____

_____

Dental Health:

Does your teen see a dentist 1-2 times a year?	□ Yes	□ No
Does your water source contain fluoride?	□ Yes (=city water)	□ No (=well water)

Tuberculosis screen:

Has your teen had close contact with a person who has tuberculosis disease or who has had a positive tuberculosis test?	□ No	□ Yes
Was your teen or any household member born in or traveled to a high-risk country? (This includes countries in Africa, Asia, Latin America, and Eastern Europe)?	□ No	□Yes

Nutrition:

Does your teen's diet include iron-rich foods daily (meat, beans, enriched cereals/cheerios)?	□ Yes	□ No
If your teen is female, does she have excessive menstrual bleeding?	□ No	□ Yes

Does your teen have interests outside of school?	□ Yes	□ No
Is your teen having any problems at school?	□ No	□ Yes
Is your teen frequently irritated?	□ No	□ Yes
Does your teen worry too much or appear overly anxious?	□ No	□ Yes
Do you have concerns about your teen's emotional health, such as being sad or depressed?	□ No	□ Yes
Have you discussed ways to deal with stress?	□ Yes	□ No
Do you help your teen make decisions and solve problems?	□ Yes	□ No
Does your family get along well with each other?	□ Yes	□ No
Do you take time to talk with your teen every day?	□ Yes	□ No
Does your family do things together?	□ Yes	□ No
Does your teen have chores and responsibilities at home?	□ Yes	□ No
Do you have rules and expectations for your teen?	□ Yes	□ No
Do you have house rules about curfews, dating, friends?	□ Yes	□ No
Do you have any concerns about your teen's nutrition, weight, or physical activity?	□ No	□ Yes
Does your teen talk about getting "fat" or dieting to lose weight?	□ No	□ Yes
Do you think your teen eats healthy foods?	□ Yes	□ No
Do you have any concerns about your teen's eating habits or nutrition?	□ No	□ Yes
Do you eat meals as a family?	□ Yes	□ No

Does your child drink sugar sweetened beverages: juice/soda/sports drinks daily?	□ No	□ Yes
Is your teen physically active at least 1 hour a day?	□ Yes	□ No
This includes running, playing sports, or doing physically active things with friends.		
Do you and your teen participate in physical activities together?	□ Yes	□ No
How much time does your teen spend on recreational screen time each day?	_____	
Does your teen have a TV, computer, tablet, or smartphone in his bedroom?	□ No	□ Yes
Do you have rules about screen time for your teen?	□ Yes	□ No
Has your teen ever bullied or been bullied?	□ No	□ Yes
Do you feel safe in your home and community?	□ Yes	□ No
Has your partner or another significant person in your life ever hurt you or your teen?	□ No	□ Yes
Do you have the things you need to take care of your teen?	□ Yes	□ No
Does your home have enough heat/AC, hot water, electricity?	□ Yes	□ No
Within the past 12 months, were you ever worried whether your food would run out?	□ No	□ Yes
Is there anyone in your teen's life whose alcohol/drug use concerns you?	□ No	□ Yes