

# Parent Questionnaire (Middle/Older Teen)

Note Age of Diagnosis to All that Apply (Boys and Girls)							
Age		Age		Age		Age	
<input type="checkbox"/>	Acne	<input type="checkbox"/>	Heart problems	<input type="checkbox"/>	Scoliosis	<input type="checkbox"/>	Autism or Aspergers
<input type="checkbox"/>	Migraine headache	<input type="checkbox"/>	Abnormal heart rhythm	<input type="checkbox"/>	Severe Menstrual Cramps	<input type="checkbox"/>	Smoking/tobacco use
<input type="checkbox"/>	Seasonal Allergies	<input type="checkbox"/>	Dizziness/fainting with exercise	<input type="checkbox"/>	Ovarian cysts	<input type="checkbox"/>	Alcohol abuse
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Blood clots	<input type="checkbox"/>	History of transfusion	<input type="checkbox"/>	Drug abuse
<input type="checkbox"/>	Mononucleosis	<input type="checkbox"/>	High cholesterol	<input type="checkbox"/>	ADD/ ADHD	<input type="checkbox"/>	Other(s)
<input type="checkbox"/>	Eczema	<input type="checkbox"/>	Food allergies	<input type="checkbox"/>	Learning disability	<input type="checkbox"/>	
<input type="checkbox"/>	Seizures	<input type="checkbox"/>	Chronic Constipation	<input type="checkbox"/>	Speech/ language delay	<input type="checkbox"/>	
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Recurrent diarrhea	<input type="checkbox"/>	Anxiety/Depression	<input type="checkbox"/>	
<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	Urinary tract infections	<input type="checkbox"/>	Eating disorder	<input type="checkbox"/>	
<input type="checkbox"/>	Autoimmune diseases	<input type="checkbox"/>	Broken Bones	<input type="checkbox"/>		<input type="checkbox"/>	

FAMILY Medical History (Check Here if Family History is Unknown or if child is adopted )	Mother	Father	Siblings	Maternal Grandparents	Paternal Grandparents	Other Family (state relationships)
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ADD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Birth Defects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding or clotting disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood disorders or sickle cell anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (type) ( _____ )	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive drinking/alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine or Gland Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack/stroke before 55 (Men)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack/stroke before 60 (Women)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental retardation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures or epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sudden cardiac death (teen or young adult)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Please help us get to know your child**

What about him/her makes you proud? \_\_\_\_\_

What seems to be the greatest Challenge for him/ her? \_\_\_\_\_

May we share your answers with your child (circle)?    Yes                      No