

# Parent Questionnaire (Young 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