SOUTHERN OREGON
PEDIATRICS

Name_____ **Date**_____ **Boy 11 to 12 Year screening**

Parent Questions

	Yes	No	Unsure
1. Do you think that your child has problems with his vision?			
2. Do you have concerns that your child has hearing loss?			
3. Has a family member or contact had TB (Tuberculosis) or a positive TB skin test?			
4. Was your child born in a country at high risk for tuberculosis (countries other than the United States, Canada, Australia, New Zealand, or Western Europe)?			
5. Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?			
6. Does your child have HIV/AIDS?			
7. Have your child's parents or grandparents had a stroke or heart problem before age 55?			
8. Does your child have a parent with high cholesterol (240 mg/dL or higher) or who is taking cholesterol medication?			
9. Does your child have any relatives who've experienced sudden unexplained death or early death (< age 50)?			
10. Does your child mainly eat a vegetarian or vegan diet?			
11. Do you have concerns that your child does NOT eat enough iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?			
12. Do you feel you have difficulties providing enough food to feed your family?			
13. Is your child ever around tobacco smoke?			

Development- Is your child doing any of the following:	Yes	No	Unsure
1. Having home or school disciplinary problems?			

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2. Getting at least 8 hours of sleep a night?			
3. Getting daily exercise for at least 30 minutes?			
4. Passing all of his classes at school?			

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Name_____ **Date**_____ **Boy 11 to 12 Year screening**

Patient Questions

	Yes	**No**	**Unsure**
1. Do you smoke cigarettes?			
2. Have you ever had low iron or anemia?			
3. Do you feel your diet lacks iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?			
4. Do you have problems with any bullies?			

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5. Do you get along well with other kids at school?			
6. Do you have friends at school?			