Children's MINNESOTA

# 12 – 14 Year Parent Questionnaire

Scan this code for age specific health information

**Date:**

**Do you have any concerns about your child's:**

No | Yes eating/nutrition?
No | Yes height or weight?
No | Yes sleeping?
No | Yes vision?
No | Yes hearing?
No | Yes screen time?

**Do you have any concerns about:**

No | Yes recent changes or stress (job change, move, divorce, illness)?
No | Yes any injury since the last visit? ☐ No injuries
No | Yes how your child is doing in school?
No | Yes your child's friends?
No | Yes your child's emotions or behavior?
No | Yes your child feeling safe at school, home, in your neighborhood?
No | Yes your child being bullied?
No | Yes use of tobacco/alcohol/drugs by your child or your child's friends?
No | Yes conflict or violence that your child is exposed to?

**Does your child:**

No | Yes eat fast food more than once a week
No | Yes get less than 1 hour of exercise per day?
No | Yes have a TV, game console, computer in their room?
No | Yes use a tanning bed?

**Do you:**

Yes | No take your child to the dentist each year?
Yes | No enforce the use of seatbelts?
Yes | No enforce the use of sunscreen?
Yes | No always supervise your child around water?
Yes | No have working smoke alarms and carbon monoxide detectors in your home?
Yes | No make sure your child uses a helmet when they are on anything with wheels, skis or snow board?
Yes | No discuss the risks of tobacco, drugs, alcohol and sex with your child?
Yes | No discuss the risks of exposure to inappropriate on-line material, bullying, predators with your child?
Yes | No If you own a gun, is it locked, with bullets stored separately? ☐ No gun in home
Yes | No have internet access to view health information from our website?

**Family Medical History**

No | Yes Have there been any changes to your family medical history?
No | Yes Is there a family history of early heart disease? (under age 65 for women, age 55 for men)
No | Yes Does your child have a parent with total cholesterol over 240 mg/dL?

**Tuberculosis (TB) Risk**

No | Yes Has your child had recent close contact with someone with active TB disease?
No | Yes Does your child have any chronic illnesses (including HIV, diabetes, cancer, kidney disease, intestinal disease)?
No | Yes Was your child born in or had extensive travel to Asia, Africa, Eastern Europe or Latin America?
No | Yes Has your child been exposed to homeless shelters, refugee camps or prison/jail?

**Please continue to the questions on Page 2**

Name: __________________________

Birthdate: __________________________

# 12 – 14 Year Parent Questionnaire continued

**Social Determinants of Health**

| | | | |
|---|---|---|---|
| Within the past 12 months, you worried that your food would run out before you got money to buy more. | ❐ Often true | ❐ Sometimes true | ❐ Never true |
| Within the past 12 months, the food you bought just didn't last and you didn't have money to get more. | ❐ Often true | ❐ Sometimes true | ❐ Never true |

In the past 12 months, has lack of transportation kept you from medical appointments, meetings, working or from getting things needed for daily living? *(check all that apply)*

- ☐ Yes, it has kept me from medical appointments or getting medication
- ☐ Yes, it has kept me from non-medical meetings, appointments, work or getting things that I need
- ☐ No

Would you like information regarding these concerns? *(check all that apply)*

☐ Yes, have someone contact me ☐ Yes, I would like written information ☐ No

**Please write down any questions or concerns that you would like to talk about today:**

Name: ______________________________

Birthdate: ______________________________

________ Provider initials