Utah Valley Pediatrics
Adolescent Health Evaluation

Name:_____ DOB:_____
School:_____ Grade:_____
Concerns:_____
_____
Extra-Curricular Activities:_____
_____

					YES	NO
For the following 2 questions- How often have you been bothered by each of the following symptoms during the past ***two weeks***? **Not at all (0) Several days (1)** **More than half the days (2) Nearly every day (3)**					Have you ever had numbness or tingling in your arms, hands, legs or feet?		
	0	1	2	3	Do you cough, wheeze, or have trouble breathing during or after activity?		
Little interest or pleasure in doing things							
Feeling down, depressed or hopeless							

	YES	NO		YES	NO
Do you feel anxious, worried or agitated?			Do you have asthma?		
Do you have disturbing thoughts about death?			Do you have allergies that requires medical treatment?		
Have you had a medical illness or injury since your last check up or physical?			Have you had any problems with your eyes or vision?		
Have you ever been hospitalized overnight? If yes, why?			Do you wear glasses or contacts?		
Are you currently taking any prescription or over the counter medications? Or use an inhaler?			Do you have any current skin problems (itching, rashes, warts, fungus or blisters)?		
Have you ever passed out or felt dizzy during or after exercise?			Have you broken or fractured any bones or dislocated any joints?		
Do you get more tired than your friends during exercise?			Have you had a sprain or strain? Or experienced swelling after an injury?		
Have you ever had chest pain during exercise?			Have you had any other problems with pain or swelling in muscles tendons, bones or joints?		
Have you ever had a "racing" heartbeat or felt your heart "skipped" a beat?			Do you have concerns with your weight?		
Have you ever been told you have a heart murmur?			Do you lose weight regularly to meet weight requirements for a sport you play?		
Has any family member or relative died of heart problems or sudden death before age 50?			**Females only**		
Has a physician ever denied or restricted your participation in sports for any reason?			When was your first menstrual period?		
Have you ever had a head injury, been knocked out, become unconscious, lost your memory or had a concussion?			Do you have any menstrual or gynecological problems?		
Have you ever become ill from exercising in the heat?			How much time do you usually have from the start of one period to the start of another?		
Do you have frequent or severe headaches?			On average, how many days does your period last?		
Have you ever had a seizure?			How many periods have you had in the last year?		
			When was your most recent menstrual period?		

Other questions or concerns?_____
_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Patient_____

Signature of Parent_____ Date_____