Utah Valley Pediatrics
Adolescent Health Evaluation

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

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)

	0	1	2	3
Little interest or pleasure in doing things (PHQ)				
Feeling down, depressed or hopeless (PHQ)				
Feeling nervous, anxious, or on edge (GAD)				
Not being able to stop or control worrying (GAD)				

	YES	NO
Have you had a medical illness or injury since your last check up or physical?		
Have you ever been hospitalized overnight? If yes, why?		
Are you currently taking any prescription or over the counter medications? Or use an inhaler?		
Have you ever passed out or felt dizzy during or after exercise?		
Do you get more tired than your friends during exercise?		
Have you ever had chest pain during exercise?		
Have you ever had a "racing" heartbeat or felt your heart "skipped" a beat?		
Have you ever been told you have a heart murmur?		
Has any family member or relative died of heart problems or sudden death before age 50?		
Has a physician ever denied or restricted your participation in sports for any reason?		
Have you ever had a head injury, been knocked out, become unconscious, lost your memory or had a concussion?		
Have you ever become ill from exercising in the heat?		
Do you have frequent or severe headaches?		
Have you ever had a seizure?		

	YES	NO
Have you had numbness or tingling in your arms, hands, legs or feet?		
Do you cough, wheeze, or have trouble breathing during or after activity?		
Do you have asthma?		
Do you have allergies that requires medical treatment?		
Have you had any problems with your eyes or vision?		
Do you wear glasses or contacts?		
Do you have any current skin problems (itching, rashes, warts, fungus or blisters)?		
Have you broken or fractured any bones or dislocated any joints?		
Have you had a sprain or strain? Or experienced swelling after an injury?		
Have you had any other problems with pain or swelling in muscles tendons, bones or joints?		
Do you have concerns with your weight?		
Do you lose weight regularly to meet weight requirements for a sport you play?		

Females only

When was your first menstrual period?

Do you have any menstrual or gynecological problems?

How much time do you usually have from the start of one period to the start of another?

On average, how many days does your period last?

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_____