SOUTH CAROLINA Children's Advocacy Medical Response System

Medical Questionnaire
Ages 13 and Above

Teenager Name _____ Date of Birth _____
Questionnaire filled out by _____
Relationship to child _____
Date of visit _____

1. Has your teenager been diagnosed with any of these illnesses or medical conditions? *(Check all that apply)*
   - ☐ Anemia
   - ☐ Asthma
   - ☐ Attention Deficit Disorder w/Hyperactivity (ADHD)
   - ☐ Diabetes
   - ☐ Head injury
   - ☐ Heart murmur
   - ☐ Nasal allergies/sinusitis
   - ☐ Psychiatric or mental illness
   - ☐ Seizures
   - ☐ Urine/bladder infection
   - ☐ Other *specify* _____

   ☐ **My teenager does not have any of these illnesses.**

2. Has your teenager ever been admitted to a hospital? ☐ Yes ☐ No
   If yes
   a. What was the admission for? _____
   b. How old was your child? _____
   c. Name of hospital and city _____

3. Has your teenager ever had any surgeries? ☐ Yes ☐ No
   If yes
   a. What was the surgery for? _____
   b. How old was your child? _____
   c. Name of hospital and city _____

4. Does your teenager have any allergies to food or medications? ☐ Yes ☐ No
   If yes, please list _____
   _____
   _____

5. Are your teenager's immunizations up to date? ☐ Yes ☐ No
   If no, which are pending? _____

6. Please check all that apply to your teenager's health at this time
   - ☐ Loss of energy
   - ☐ Weight loss
   - ☐ Weight gain
   - ☐ Gums bleed easily
   - ☐ Bleeds for a long time after a cut
   - ☐ Difficulty hearing
   - ☐ Teeth are discolored and break easily
   - ☐ Hives
   - ☐ Eczema
   - ☐ Muscle aches
   - ☐ Joint pain or swelling
   - ☐ Trouble with eyesight
   - ☐ Wears glasses
   - ☐ Wheezing

   ☐ **My teenager does not have any of these problems.**

7. Is your teenager taking any medications or vitamins now? ☐ Yes ☐ No
   If yes, what is he/she taking? _____
   _____
   What illness/condition is he/she taking this for? _____
   _____
   Has your teenager ever used birth control that was prescribed by a doctor?
   ☐ Yes ☐ No
   If yes, what kind? _____ For how long? _____

8. Who is your teenager's doctor? _____
   In what town/city does the doctor have his/her practice? _____

Family Medical History

Do any of your teenager's siblings, parents or grandparents suffer any of the following medical conditions? *(Check all that apply and identify the family member affected by each illness)*

- ☐ Anemia _____
- ☐ Asthma _____
- ☐ Delay in talking, moving around or understanding things
  _____
- ☐ Diabetes _____
- ☐ Drug/alcohol addiction _____
- ☐ Had a lot of broken bones _____
- ☐ Had a lot of discolored, broken or chipped teeth _____
- ☐ Heart disease _____
- ☐ HIV/AIDS _____
- ☐ Loss of hearing _____
- ☐ Mental retardation _____
- ☐ Nasal allergies _____
- ☐ Nosebleeds; bruises easily _____
- ☐ Psychiatric or mental illness _____

- ☐ Seizures _____
- ☐ Does anyone in your household smoke? _____
- ☐ Other *(please list)* _____

☐ **No one in my family has any of these illnesses.**

School Attendance

a. Please give the name and location of the school your teenager attends: _____
_____

b. Which grade is your teenager in? _____

c. How is your teenager doing in school?
☐ Excellent ☐ Good ☐ Average ☐ Failing

d. If your teenager is failing at school, what is the problem? _____
_____
_____
_____
_____
_____

Social History

a. Please list all adults and children currently living in same home as your teenager and their relationship to your teenager: _____
_____
_____
_____
_____
_____
_____
_____

b. Has your family had any previous involvement with DSS? ☐ Yes ☐ No
If yes, please list the year and reason for involvement: _____
_____
_____
_____
_____

c. Has your child ever been around domestic violence? ☐ Yes ☐ No

Additional Comments by Healthcare Provider:

Questionnaire reviewed by: _____ Review Date _____
Healthcare Provider