Waukesha Pediatric Associates Health Questionnaire

Name _____ DOB:_____ Date:_____

Grade:_____ School:_____

1. Habits

a. Have you smoked in the past month?	Yes	No
b. Have you used chewing tobacco, snuff, or dip in the past month?	Yes	No
c. Have you used e-cigarettes or juuled in the last month?	Yes	No
d. Are you exposed to smoke at home?	Yes	No
e. In the past 30 days, have you had any alcohol?	Yes	No
f. Have you ever taken steroids or supplements to improve your performance?	Yes	No
g. Any other drug use?	Yes	No
h. Do you wear a seat belt regularly?	Yes	No
i. Do you wear a bike helmet?	Yes	No

General Questions

WHICH SPORTS DO YOU PLAN TO PLAY?

☐ Baseball (limited-contact)
☐ Basketball (contact)
☐ Cross Country (non-contact)
☐ Diving (contact)
☐ Football (contact)
☐ Golf (non-contact)
☐ Gymnastics (contact)
☐ Hockey (contact)
☐ Lacrosse (contact)
☐ Soccer (contact)
☐ Softball (limited-contact)
☐ Swimming (non-contact)
☐ Tennis (non-contact)
☐ Track & Field (limited contact)
☐ Volleyball (limited-contact)
☐ Wrestling (contact)
☐ Other, please specify _____
☐ None at this time

Has a provider ever denied or restricted your participation in sports for any reason? ☐ Yes ☐ No
If yes, please provide further information:

Do you have any ongoing medical issues or recent illness? ☐ Yes ☐ No
If yes, please provide further information:

Have you ever had surgery? ☐ Yes ☐ No
If yes, please provide further information:

Heart Health Questions About You

Have you ever passed out or nearly passed out DURING or AFTER exercise? ☐ Yes ☐ No
If yes, please provide further information:

Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? ☐ Yes ☐ No
If yes, please provide further information:

Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise? ☐ Yes ☐ No
If yes, please provide further information:

Has a doctor ever told you that you have any heart problems? ☐ Yes ☐ No
If yes, please provide further information:

Has a doctor ever requested a test for your heart-For example, electrocardiography (ECG) or echocardiography? ☐ Yes ☐ No
If yes, please provide further information:

Do you get lightheaded or feel shorter of breath than your friends during exercise? ☐ Yes ☐ No
If yes, please provide further information:

Have you ever had a seizure? ☐ Yes ☐ No
If yes, please provide further information:

Heart Health Questions About Your Family

Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning, unexplained car crash)? ☐ Yes ☐ No
If yes, please provide further information:

Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)? ☐ Yes ☐ No
If yes, please provide further information:

Has anyone in your family had a pacemaker, or implanted defibrillator before the age of 35? ☐ Yes ☐ No
If yes, please provide further information:

Complete other side--→

Bone and Joint Questions

Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game? ☐ Yes ☐ No
If yes, please provide further information:

Do you have a bone, muscle, ligament, or joint injury that bothers you? ☐ Yes ☐ No
If yes, please provide further information:

Medical Questions

Do you cough, wheeze, or have difficulty breathing during or after exercise? ☐ Yes ☐ No
If yes, please provide further information:

Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ? ☐ Yes ☐ No
If yes, please provide further information:

Do you have groin or testicle pain or a painful bulge or hernia in the groin area? ☐ Yes ☐ No
If yes, please provide further information:

Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)? ☐ Yes ☐ No
If yes, please provide further information:

Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems? ☐ Yes ☐ No
If yes, please provide further information:

Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling? ☐ Yes ☐ No
If yes, please provide further information:

Have you ever become ill while exercising in the heat? ☐ Yes ☐ No
If yes, please provide further information:

Do you or does someone in your family have sickle cell trait or disease? ☐ Yes ☐ No
If yes, please provide further information:

Have you ever had or do you have any problems with your eyes or vision? ☐ Yes ☐ No
If yes, please provide further information:

Do you worry about your weight? ☐ Yes ☐ No
If yes, please provide further information:

Are you trying to or has anyone recommended that you gain or lose weight? ☐ Yes ☐ No
If yes, please provide further information:

Are you on a special diet or do you avoid certain types of foods or food groups? ☐ Yes ☐ No
If yes, please provide further information:

Have you ever had an eating disorder? ☐ Yes ☐ No
If yes, please provide further information:

Do you have any concerns that you would like to discuss with your provider? ☐ Yes ☐ No
If yes, please provide further information:

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Feeling nervous, anxious, or on edge	0 - Not at all	1 - Several days	2 - Over half the days	3 – Nearly every day
Not being able to stop or control worrying	0 - Not at all	1 - Several days	2 - Over half the days	3 – Nearly every day
Little interest or pleasure in doing things	0 - Not at all	1 - Several days	2 - Over half the days	3 – Nearly every day
Feeling down, depressed, or hopeless	0 - Not at all	1 - Several days	2 - Over half the days	3 – Nearly every day

FEMALES ONLY

Have you ever had a menstrual period? ☐ Yes ☐ No
How old were you when you had your first menstrual period? _____
When was your most recent menstrual period? _____
How many periods have you had in the past 12 months? _____

Any concerns to discuss with your doctor? (sleep problems, acne, etc., please briefly describe):