CHILD & ADOLESCENT HEALTH ASSOCIATES SCREENING QUESTIONNAIRE

Patient Name: _____ **Date of Birth:** _____

Person Filling this Form: _____ **Age of patient at Visit:** _____**(months or years)**

Relationship to Patient: _____ **Date of Visit:** _____

ALL AGES - Please answer the following TUBERCULOSIS SCREENING QUESTIONS		
	Yes	**No**
1. Does your child have close contact with anyone who has tuberculosis disease or a positive skin test?		
2. Was anyone in your household born outside the US?		
If yes, has that person tested negative for tuberculosis since living in the US?		
3. Has your child stayed **with local family or friends for longer than 1 week** in Africa, Asia, Latin America or Eastern Europe? If yes, has that person tested negative for TB since back in the US?		
4. Have you had visitors from a high-risk area as listed above stay with you for **longer than 1 week**?		
5. Does anyone in your household work or volunteer in a jail/prison, nursing home, or shelter?		
6. Does anyone in your household have close contact with someone who uses drugs or has HIV?		

AGES 2 YEARS AND UP – Please answer the following CHOLESTEROL SCREENING and DIABETES QUESTIONS		
	Yes	**No**
1. Does early heart disease (males younger than age 55, females younger than age 65) or high cholesterol run in your family?		
2. Does diabetes run in your family?		
3. Is your child exposed to tobacco smoke?		
4. Does your child spend ≥ 2 hours per day with screen time (computer, video games, phone apps)?		
5. Does your child have a TV in his or her bedroom?		
6. Does your child spend less than an hour each day being physically active?		

AGES 10 YEARS AND UP – Please answer the following DEPRESSION SCREENING QUESTIONS (Circle answers)

In the past 2 weeks, how often has your child …	Not at all	Several days	More than ½ the days	Nearly every day
1. Had little interest or pleasure in doing things he or she usually likes to do?	0	1	2	3
2. Been feeling down, depressed, or hopeless?	0	1	2	3

IF YOUR CHILD IS INVOLVED IN SPORTS, please answer the following SPORTS PRE-PARTICIPATION QUESTIONS		
	Yes	**No**
1. Has your child ever passed out, felt dizzy, or had chest pains during or after exercise?		
2. Does your child have high blood pressure?		
3. Does your child have a heart murmur?		
4. Has your child had racing, skipped, or irregular heartbeats?		
5. Do you have a family history of sudden death before age 50?		
6. Does your child have difficulty with breathing, wheezing, or coughing fits with exercise?		
7. Has your child had a seizure in the past 6 months?		
8. Has your child been diagnosed recently with infectious mono?		
9. Does your child have only one eye, kidney, testicle or ovary?		
10. Has your child had previous injuries to any joints or bones?		