

Maryland Healthy Kids Program Medical/Family History Questionnaire

Patient Name: _____		Date of Birth: _____	Sex: (circle) Male Female
Form Completed By: _____	Today's Date _____	Relationship: _____	
PREGNANCY AND BIRTH HISTORY		PSYCHOSOCIAL HISTORY	
<p>Name of Hospital: _____</p> <p>Illnesses during pregnancy? No <input type="checkbox"/> Yes <input type="checkbox"/></p> <p>Medications during pregnancy? No <input type="checkbox"/> Yes <input type="checkbox"/></p> <p>Alcohol/Drug Abuse? No <input type="checkbox"/> Yes <input type="checkbox"/></p> <p>Problems at birth? No <input type="checkbox"/> Yes <input type="checkbox"/></p> <p>Describe: _____</p> <p>Type of delivery? <input type="checkbox"/> Vaginal <input type="checkbox"/> C-section</p> <p>Birth Weight _____ Discharge Weight _____</p> <p>Did baby receive Hepatitis B vaccine? No <input type="checkbox"/> Yes <input type="checkbox"/></p> <p>Date of Hepatitis B immunization: _____</p> <p>Newborn Hearing Screen? No <input type="checkbox"/> Yes <input type="checkbox"/></p>		<p>Who lives in household? _____</p> <p>How many? _____</p> <p><input type="checkbox"/> Rent? <input type="checkbox"/> Own? <input type="checkbox"/> Shelter?</p> <p>Who cares for child? _____</p> <p>Date of Birth? Mother _____ Father _____</p> <p>Are parents working? Mother No <input type="checkbox"/> Yes <input type="checkbox"/> Father No <input type="checkbox"/> Yes <input type="checkbox"/></p> <p>Foster Care? Dates: _____</p> <p>Other Languages? _____</p>	
FAMILY HISTORY		MEDICAL HISTORY	
<p>Has anyone in the family (parents, grand-parents, aunts/uncles, sisters/brothers) had:</p> <p style="text-align: right; margin-right: 20px;">Who?</p> <p>Allergies (List) _____ No <input type="checkbox"/> Yes <input type="checkbox"/> _____</p> <p>Asthma No <input type="checkbox"/> Yes <input type="checkbox"/> _____</p> <p>TB/Lung Disease No <input type="checkbox"/> Yes <input type="checkbox"/> _____</p> <p>HIV/AIDS No <input type="checkbox"/> Yes <input type="checkbox"/> _____</p> <p>Suicide Attempts No <input type="checkbox"/> Yes <input type="checkbox"/> _____</p> <p>Heart Disease No <input type="checkbox"/> Yes <input type="checkbox"/> _____</p> <p>High Blood Pressure/Stroke No <input type="checkbox"/> Yes <input type="checkbox"/> _____</p> <p>High Cholesterol No <input type="checkbox"/> Yes <input type="checkbox"/> _____</p> <p>Blood Disorders/Sickle Cell No <input type="checkbox"/> Yes <input type="checkbox"/> _____</p> <p>Diabetes No <input type="checkbox"/> Yes <input type="checkbox"/> _____</p> <p>Seizures No <input type="checkbox"/> Yes <input type="checkbox"/> _____</p> <p>Mental Illness No <input type="checkbox"/> Yes <input type="checkbox"/> _____</p> <p>Cancer No <input type="checkbox"/> Yes <input type="checkbox"/> _____</p> <p>Birth Defects No <input type="checkbox"/> Yes <input type="checkbox"/> _____</p> <p>Hearing Loss No <input type="checkbox"/> Yes <input type="checkbox"/> _____</p> <p>Speech Problems No <input type="checkbox"/> Yes <input type="checkbox"/> _____</p> <p>Kidney Disease No <input type="checkbox"/> Yes <input type="checkbox"/> _____</p> <p>Alcohol/Drug Abuse No <input type="checkbox"/> Yes <input type="checkbox"/> _____</p> <p>Hepatitis/Liver Disease No <input type="checkbox"/> Yes <input type="checkbox"/> _____</p> <p>Thyroid Disease No <input type="checkbox"/> Yes <input type="checkbox"/> _____</p> <p>Learning Problems/Attention Deficit Disorder No <input type="checkbox"/> Yes <input type="checkbox"/> _____</p> <p>Family Violence No <input type="checkbox"/> Yes <input type="checkbox"/> _____</p> <p>Other: _____</p>		<p>Has your child ever had:</p> <p>Allergies (List) _____ No <input type="checkbox"/> Yes <input type="checkbox"/></p> <p>Asthma No <input type="checkbox"/> Yes <input type="checkbox"/></p> <p>Chicken Pox (Year) _____ No <input type="checkbox"/> Yes <input type="checkbox"/></p> <p>Frequent Ear Infections No <input type="checkbox"/> Yes <input type="checkbox"/></p> <p>Vision/Hearing Problems No <input type="checkbox"/> Yes <input type="checkbox"/></p> <p>Skin Problems/Eczema No <input type="checkbox"/> Yes <input type="checkbox"/></p> <p>TB/Lung Disease No <input type="checkbox"/> Yes <input type="checkbox"/></p> <p>Seizures/Epilepsy No <input type="checkbox"/> Yes <input type="checkbox"/></p> <p>High Blood Pressure No <input type="checkbox"/> Yes <input type="checkbox"/></p> <p>Heart Defects/Disease No <input type="checkbox"/> Yes <input type="checkbox"/></p> <p>Liver Disease/Hepatitis No <input type="checkbox"/> Yes <input type="checkbox"/></p> <p>Diabetes No <input type="checkbox"/> Yes <input type="checkbox"/></p> <p>Kidney Disease/Bladder Infections No <input type="checkbox"/> Yes <input type="checkbox"/></p> <p>Physical or Learning Disabilities No <input type="checkbox"/> Yes <input type="checkbox"/></p> <p>Bleeding Disorders/Hemophilia No <input type="checkbox"/> Yes <input type="checkbox"/></p> <p>Sexually Transmitted Diseases No <input type="checkbox"/> Yes <input type="checkbox"/></p> <p>Emotional or Behavioral Problems No <input type="checkbox"/> Yes <input type="checkbox"/></p> <p>Depression/Suicidal Thoughts No <input type="checkbox"/> Yes <input type="checkbox"/></p> <p>Hospitalizations/Surgeries No <input type="checkbox"/> Yes <input type="checkbox"/></p> <p>Physical/Emotional/ Sexual Abuse No <input type="checkbox"/> Yes <input type="checkbox"/></p> <p>Bone or Joint Injuries No <input type="checkbox"/> Yes <input type="checkbox"/></p> <p>Obesity/Eating Disorders No <input type="checkbox"/> Yes <input type="checkbox"/></p> <p>Other: _____ No <input type="checkbox"/> Yes <input type="checkbox"/></p> <p>_____</p> <p>Current Medication(s): (List) _____</p> <p>_____</p>	
Reviewed by: _____		Date of Review: _____	

NUTRITION QUESTIONNAIRE FOR ADOLESCENTS AGES 11 TO 21

1. Which of these meals or snacks did you eat yesterday?
(Check all that apply)
 - Breakfast
 - Lunch
 - Dinner or supper
 - Morning snack
 - Afternoon Snack
 - Evening/late-snack
2. Do you skip breakfast 3 or more times a week?
 - Yes NoDo you skip lunch 3 or more times a week?
 - Yes NoDo you skip dinner or supper 3 or more times a week?
 - Yes No
3. Do you eat dinner or supper with your family 4 or more times a week?
 - Yes No
4. Do you fix or buy the food for any of your family's meals?
 - Yes No
5. Do you eat or take out a meal from a fast food restaurant 2 or more times a week?
 - Yes No
6. Are you on special diet for medical reasons?
 - Yes No
7. Are you a vegetarian?
 - Yes No
8. Do you have any problems with your appetite, like not feeling hungry, or feeling hungry all the time?
 - Yes No
9. Which of the following did you drink last week?(Check all that apply)
 - Tap or bottled water
 - Fitness water
 - Juice
 - Regular soft drinks
 - Diet soft drinks
 - Fruit-flavored drinks
 - Sport drinks
 - Energy drinks
 - Recovery drinks
 - Fat-free (skim) milk
 - Low-fat (1%) milk
 - Reduced-fat (2%) milk
 - Whole milk
 - Flavored milk (for example, chocolate, strawberry)
 - Coffee or tea
 - Beer, wine, or hard liquor
10. Which of these foods did you eat last week?
(Check all that apply)
 - Grains:**
 - Bagels
 - Bread
 - Cereal/grits
 - Crackers
 - Muffins
 - Noodles/pasta/rice
 - Rolls
 - Tortillas
 - Other grains:.....
 - Vegetables**
 - Broccoli
 - Carrots
 - Corn
 - Green beans
 - Green salad
 - Greens (collard, spinach)
 - Peas
 - Potatoes
 - Tomatoes
 - Other vegetables.....
 - Fruits**
 - Apples/ juice
 - Bananas
 - Grapefruit/juice
 - Grapes/juice

NUTRITION QUESTIONNAIRE FOR ADOLESCENTS AGES 11 TO 21

- Melon
- Oranges/juice
- Peaches
- Pears
- Other fruits/juice:.....

Milk and Milk Products

- Fat-free (skim) milk
- Low-fat (1%) milk
- Reduced-fat (2%) milk
- Whole milk
- Flavored milk
- Cheese
- Ice cream
- Yogurt
- Other milk and milk products:

Meal and Meal Alternatives

- Beef/hamburger
- Chicken
- Cold cuts/deli meals
- Dried beans (for example, black beans, kidney beans, pinto beans)
- Eggs
- Fish
- Peanut butter/nuts
- Pork
- Sausage/bacon
- Tofu
- Turkey
- Other meal and meat alternatives:.....

Fats and Sweets

- Cake/cupcakes
- Candy
- Chips
- French fries
- Cookies
- Doughnuts
- Fruit-flavored drinks
- Pies
- Soft drinks
- Other fats and sweets:

11. Do you have a working stove, oven, and refrigerator where you live?
- Yes No

12. Were there any days last month when your family didn't have enough food to eat or enough money to buy food?
- Yes No

13. Are you concerned about your weight?
- Yes No

14. Are you on a diet now to lose weight or to maintain your weight?
- Yes No

15. In the past year, have you tried to lose weight or control your weight by vomiting, taking diet pill or laxatives, or not eating?
- Yes No

16. Did you participate in physical activity (for example, walking or riding a bike) in the past week?
- Yes No
- If yes, on how many days and for how many minutes or hours per day?.....

17. Did you spend more than 2 hours per day watching television and DVDs or playing computer games?
- Yes No
- If yes, how many hours per day?.....

18. Does the family watch television during meals?
- Yes No

19. Do you take vitamin, mineral, herbal, or other dietary supplements (for example, protein powders)?
- Yes No

20. Do you smoke cigarettes or chew tobacco?
- Yes No

21. Do you ever use any of the following? (Check all that apply)
- Alcohol, beer, or wine
 - Steroids (without a doctor's permission)
 - Street drugs (marihuana, speed, crack, or heroin)

MARYLAND HEALTHY KIDS PROGRAM

Preventive Screen Questionnaire

Lead Risk Assessment:
(every well child visit from 6 months up to 6 years)

- | | | | | | | | | | |
|--|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 1. Has your child ever lived or stayed in a house or apartment that is built before 1978 (includes day care center, preschool home, home of babysitter or relative)? | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| 2. Has your child ever lived outside the United States or recently arrived from a foreign country? | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| 3. Is anyone in the home being treated or followed for lead poisoning? | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| 4. Are there any current renovations or peeling paint in a home that your child regularly visits? | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| 5. Does your child lick, eat, or chew things that are not food (paint chips, dirt, railings, poles, furniture, old toys, etc.)? | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| 6. Is there any family member who is currently working in an occupation or hobby where lead exposure could occur (auto mechanic, ceramics, commercial painter, etc.)? | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| 7. Does your family use products from other countries such as health remedies, traditional remedies, spices, cosmetics or other products canned or packaged outside of the United States? Or store or serve food in leaded crystal, pottery or pewter?
<i>Examples: Glazed pottery, Greta, Azarcon (Rueda, Coral, Lliga), Litargirio, Summa, Kohl (Al Kohl), Pay-loo-ah, Ayurvedic medicine, Ghassard).</i> | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |

Tuberculosis Risk Assessment:

(The assessment must be completed at 1, 6 and 12 months, and then annually starting at 36 months.)

- | | Date | Date | Date | Date | Date | Date | Date | Date | Date |
|--|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 1. Has your child been exposed to anyone with a case of TB or a positive tuberculin skin test, or received a tuberculosis vaccination? | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| 2. Was your child, or a household member, born in a high-risk country (countries other than the United States, Canada, Australia, New Zealand, or Western and North European countries)? | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| 3. Has your child travelled (had a contact with resident populations) to a high-risk country for more than 1 week? | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| 4. Does your child have daily contact with adults at high risk for TB (e.g., those who are HIV infected, homeless, incarcerated, and/or illicit drug users)? | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| 5. Does your child have HIV infection? | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |

(A "yes" response or "don't know" to any question indicates a positive risk)

Patient Name: _____

Birth Date: _____

MARYLAND HEALTHY KIDS PROGRAM

Preventive Screen Questionnaire

Anemia Screening
(Starting at 11 years of age and annually thereafter)

- (FEMALES AND MALES) Does the child/adolescent's diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?
Y / N Y / N Y / N Y / N Y / N Y / N Y / N Y / N Y / N Y / N
- (FEMALES AND MALES) Have you ever been diagnosed with iron deficiency anemia?
Y / N Y / N Y / N Y / N Y / N Y / N Y / N Y / N Y / N Y / N
- (FEMALES ONLY) Do you have excessive menstrual bleeding or other blood loss?
Y / N Y / N Y / N Y / N Y / N Y / N Y / N Y / N Y / N Y / N
- (FEMALES ONLY) Does your period last more than 5 days?
Y / N Y / N Y / N Y / N Y / N Y / N Y / N Y / N Y / N Y / N

Heart Disease/Cholesterol Risk Assessment:
(2 years through 20 years)

- Is there a family history of parents/grandparents under 55 years of age with a heart attack, heart surgery, angina or sudden cardiac death?
Y / N Y / N Y / N Y / N Y / N Y / N Y / N Y / N Y / N Y / N
- Has the child's mother or father been diagnosed with high cholesterol (240 mg/dL or higher)?
Y / N Y / N Y / N Y / N Y / N Y / N Y / N Y / N Y / N Y / N
- Is the child/adolescent overweight (BMI > 85th %)?
Y / N Y / N Y / N Y / N Y / N Y / N Y / N Y / N Y / N Y / N
- And is there a personal history of:
Smoking? Y / N Y / N Y / N Y / N Y / N Y / N Y / N Y / N Y / N
Lack of physical activity? Y / N Y / N Y / N Y / N Y / N Y / N Y / N Y / N Y / N
High blood pressure? Y / N Y / N Y / N Y / N Y / N Y / N Y / N Y / N Y / N
High cholesterol?
Diabetes mellitus?

(Refer to the AAP Clinical Guidelines for Childhood Lipid Screening)

STI/HIV Risk Assessment:
(11 years through 20 years)

- Are you sexually active?
Y / N Y / N Y / N Y / N Y / N Y / N Y / N Y / N Y / N Y / N
- If sexually active, have you had more than one partner?
Y / N Y / N Y / N Y / N Y / N Y / N Y / N Y / N Y / N Y / N
- If sexually active, have you had unprotected sex, with opposite/same sex?
Y / N Y / N Y / N Y / N Y / N Y / N Y / N Y / N Y / N Y / N
- Have you ever been sexually molested or physically attacked?
Y / N Y / N Y / N Y / N Y / N Y / N Y / N Y / N Y / N Y / N
- Have you ever been diagnosed with any sexually transmitted diseases?
Y / N Y / N Y / N Y / N Y / N Y / N Y / N Y / N Y / N Y / N
- Any body tattoos or body piercing of ears, navel, etc., including any performed by friends?
Y / N Y / N Y / N Y / N Y / N Y / N Y / N Y / N Y / N Y / N
- Have you had a blood transfusion or are you a Hemophiliac?
Y / N Y / N Y / N Y / N Y / N Y / N Y / N Y / N Y / N Y / N
- Any history of IV drug use by you, your sex partner, or your birth mother during pregnancy?
Y / N Y / N Y / N Y / N Y / N Y / N Y / N Y / N Y / N Y / N

A "yes" response or "don't know" to any question indicates a positive risk

Patient Name: _____ Birth Date: _____

MENTAL HEALTH QUESTIONNAIRE

Maryland Healthy Kids Program

Date _____

Child's Name: _____ Date of Birth: _____

Managed Care Organization: _____ Child's Medicaid #: _____

Ages 10 – 12 years

Check all answers that may apply. This form may be filled out by the parent/guardian or health care provider.

Does your child have trouble paying attention? Yes No

Does your child often seem:

Distrustful of others? Yes No

To express strange thoughts?..... Yes No

Blame others? Yes No

Does your child have problems at school with:

Behavior?..... Yes No

Grades? Yes No

Skipping classes?..... Yes No

Do you have concerns about your child's:

Eating? Yes No

Sleep? Yes No

Weight? Yes No

Does your child often complain of "not feeling well"? Yes No

Does your child have trouble making or keeping friends? Yes No

Does your child often seem:

Sad? Yes No

Angry?..... Yes No

Nervous or afraid?..... Yes No

Does your child show any of these behaviors?

Destroy property? Yes No

Set fire? Yes No

Lie? Yes No

Steal? Yes No

Listen to music with violent message? Yes No

Hurt animal or smaller children? Yes No

Use alcohol? Yes No

Use drugs?..... Yes No

Smoke cigarettes? Yes No

Sexually active? Yes No

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MARYLAND HEALTHY KIDS PROGRAM

Maryland Department of Health and Mental Hygiene HealthChoice and
Acute Care Administration, Division of Children's Services

MENTAL HEALTH QUESTIONNAIRE

Maryland Healthy Kids Program

Page Two

Is there a history of injuries, accidents? Yes No

If yes, please specify: _____

Is there any history of maltreatment or abuse? Yes No

If yes, please specify: _____

Is there a recent stress on the family or child such as:

Birth of a child Yes No

Moving Yes No

Divorce or separation Yes No

Death of a close relative Yes No

Fired or laid off Yes No

Legal problems Yes No

Others (Please specify): _____

Do you have other parenting concerns? Yes No

Please specify: _____

Provider: Give details of all **Positive** findings.

Provider's Signature

Date

Provider's Phone: (____) / ____ / _____

THIS FORM MAY BE USED FOR MENTAL HEALTH REFERRALS

Child Receiving Referral: _____

Child's Address: _____

Child's Phone: _____

Referred to: **Maryland Public Mental Health System: 1-800-888-1965**

Reason for Referral: _____

MARYLAND HEALTHY KIDS PROGRAM

**Maryland Department of Health and Mental Hygiene HealthChoice and
Acute Care Administration, Division of Children's Services**

The CRAFFT Screening Questions

Please answer all questions honestly; your answers will be kept confidential.

Part A

During the PAST 12 MONTHS, did you:

1. Drink any alcohol (more than a few sips)?

No

Yes

2. Smoke any marijuana or hashish?

3. Use anything else to get high?

"anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff"

If you answered NO to ALL (A1, A2, A3) answer only B1 below, then STOP.

If you answered YES to ANY (A1 to A3), answer B1 to B6 below.

Part B

1. Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?

No

Yes

2. Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?

3. Do you ever use alcohol or drugs while you are by yourself, or ALONE?

4. Do you ever FORGET things you did while using alcohol or drugs?

5. Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?

6. Have you ever gotten into TROUBLE while you were using alcohol or drugs?

CONFIDENTIALITY NOTICE:

The information on this page may be protected by special federal confidentiality rules (42 CFR Part 2), which prohibit disclosure of this information unless authorized by specific written consent. A general authorization for release of medical information is NOT sufficient.

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A Survey From Your Healthcare Provider — PHQ-9 Modified for Teens

Name _____ Clinician _____

Medical Record or ID Number _____ Date _____

Instructions: How often have you been bothered by each of the following symptoms during the past two weeks?
For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.

	(0) Not At All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself — or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

10. In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes? Yes No

11. If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?
 Not difficult at all Somewhat difficult Very difficult Extremely difficult

12. Has there been a time in the past month when you have had serious thoughts about ending your life? Yes No

13. Have you **ever**, in your **whole life**, tried to kill yourself or made a suicide attempt? Yes No

FOR OFFICE USE ONLY Score _____

Q. 12 and Q. 13 = Y or TS = ≥11