Patient Name_____

Date of Birth _____

Risk Assessment 15-17 Years

Do you have at least one responsible adult in your life who cares and you can go to if needed for help?	**YES**	**NO**
Do you have at least one friend or group of friends with whom you are comfortable**?**	**YES**	**NO**
Have you become more independent and made more of your own decisions	**YES**	**NO**
Do you have any concerns about body image?	**NO**	**YES**

Vision and Hearing Screen:

Is blackboard at school difficult to see?	**NO**	**YES**
Failed School vision test	**NO**	**YES**
Do you squint?	**NO**	**YES**
Do you have problems hearing over the telephone?	**NO**	**YES**
Do you find yourself asking people to repeat themselves?	**NO**	**YES**

Servings of fruit & vegetables per day	More than 4 per day	3-4 per day	1-2 per day	0-1 per day
Eats out each week	0-1 times	1-2 times	3-4 times	More than 4 times
Activity level	More than 60 min per day	30-60 min per day	Less than 30 min per day	Not very often
Sweet drinks per day	Not very often	1 per day	2 per day	More than 3 per day
TV/screen time	Not very often	30-60 min/d	1-2hr/d	More than 2hr/d

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TB risk

Were you born in a country outside the U.S.	**NO**	**YES**
Have you traveled or had contact with High Risk Tb population	**NO**	**YES**
Has a family member or contact had tuberculosis or positive skin test	**NO**	**YES**
Have you tested positive for HIV	**NO**	**YES**

Anemia Risk

Have you been diagnosed with iron deficiency anemia	**NO**		**YES**
Does your diet include iron-rich foods Such as meat, eggs, iron fortified cereal or beans	**YES**		**NO**
Do you go to school	**YES**		**NO**
Having any problems in school	**NO**	**Sometimes**	**YES**
Do you receive healthcare from anyone besides pediatrician	**NO**		**YES**
Do you live in parent's home	**YES**	**Sometimes**	**NO**
Do you eat meals together as family at least once a week	**YES**		**NO**
Always wears a seat belt when riding in car, truck or van	**YES**	**Sometimes**	**NO**
Do you or anyone you live with have a gun, rifle or firearm	**NO**	**Sometimes**	**YES**

Wears helmet/protective gear when biking, skating, skiing, or snowboarding	**YES**	**Sometimes**	**NO**
Are you starting to learn to drive	**YES**	**Sometimes**	**NO**
Do you ever use a cellphone or headphones while driving	**NO**		**YES**
Do you get along with your family	**YES**		**NO**
In general do you follow your family's rules	**YES**		**NO**

Cardiac Risk: Have you ever had:

Fainting during or after exercise, emotion or startle?	**NO**	**YES**
Extreme shortness of breath with exercise?	**NO**	**YES**
Discomfort, pain, or pressure in chest during exercise?	**NO**	**YES**