

**COOKEVILLE PEDIATRIC ASSOCIATES**  
**11-21 YEAR CHECKUP QUESTIONNAIRE**

PATIENT: \_\_\_\_\_ GUARANTOR: \_\_\_\_\_  
DOB: \_\_\_/\_\_\_/\_\_\_ DATE: \_\_\_/\_\_\_/\_\_\_

Source of information: (check one)  
Patient \_\_\_\_\_ Mother \_\_\_\_\_ Father \_\_\_\_\_  
Other (specify) \_\_\_\_\_

Which of the following do you have? (check one)  
City water \_\_\_\_\_ Well water \_\_\_\_\_ Bottled water \_\_\_\_\_ Spring water \_\_\_\_\_

Has the child experienced any of the following?

Hearing loss:	Yes _____	No _____
Evidence of hearing loss:	Yes _____	No _____
Difficulty in speech:	Yes _____	No _____
Eyesight problems:	Yes _____	No _____
Family history of high cholesterol:	Yes _____	No _____
Family history of heart attacks before age 55:	Yes _____	No _____

DIETARY HISTORY:

Milk – type and amount \_\_\_\_\_

Fruit: \_\_\_\_\_

Vegetables \_\_\_\_\_

Meat \_\_\_\_\_

Snacks \_\_\_\_\_

Caloric beverages – type and amount \_\_\_\_\_

EDUCATION LEVEL: \_\_\_\_\_

GOOD SCHOOL PERFORMANCE Yes \_\_\_\_\_ No \_\_\_\_\_

DEVELOPMENTAL:

Appropriate home behavior	Yes _____	No _____
Appropriate school behavior	Yes _____	No _____
Appropriate behavior playing w/friend	Yes _____	No _____

Reading – doing math at grade level Yes \_\_\_\_\_ No \_\_\_\_\_

Pride in achievement	Yes _____	No _____
Talks about what goes on in school	Yes _____	No _____
Completes school work	Yes _____	No _____
Delayed developmental milestones	Yes _____	No _____

FOR GIRLS: No period (check if correct) \_\_\_\_\_

Normal period Yes \_\_\_\_\_ No \_\_\_\_\_

Last menstrual period \_\_\_\_\_

How long do they last? \_\_\_\_\_ days

First period at age \_\_\_\_\_ yrs old

Any abnormal periods? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, how often? \_\_\_\_\_

If so, how long do they last? \_\_\_\_\_

**TUBERCULOSIS: (Mandatory questions)**

Has the child been in close contact with a person with infectious tuberculosis?

Yes \_\_\_ No \_\_\_ Unsure \_\_\_

Does the child have HIV infection or considered at risk for HIV infection?

Yes \_\_\_ No \_\_\_ Unsure \_\_\_

Is the child foreign born (especially if born in Asia, Africa or Latin America), a refugee, or an immigrant?

Yes \_\_\_ No \_\_\_ Unsure \_\_\_

Is the child in contact with the following individuals? HIV infected, homeless, nursing home residents, institutionalized or incarcerated adolescents or adults, illicit drug users or immigrant farm workers?

Yes \_\_\_ No \_\_\_ Unsure \_\_\_

Does the child have a depressed immune system, either because of disease or treatment of disease?

Yes \_\_\_ No \_\_\_ Unsure \_\_\_

Does the child live in an established "high risk for tuberculosis" community or area?

Yes \_\_\_ No \_\_\_ Unsure \_\_\_

## Risk Assessment Questionnaire

Patient's Name \_\_\_\_\_

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Assessment Date \_\_\_\_/\_\_\_\_/\_\_\_\_

### Lead (ages 6 – 72 months): Mandatory questions

	Yes	No	Unsure
Does the child live in or regularly visit a house/apartment built before 1960? This could include a daycare center, home of a baby sitter, or a relative.)			
Does the child live in or regularly visit a house/apartment built before 1978 with recent or ongoing remodeling?			
Does the child have a sibling or a playmate that has, or did have lead poisoning?			

### Lead (ages 6 – 72 months): Optional questions

	Yes	No	Unsure
Does child live near or visit with someone who lives near a lead smelter, battery recycling plant or other industry that could release lead or has a hobby which uses lead such as welding, construction, or pottery making?			
Does your child frequently come in contact with an adult who works with lead (construction, welding, pottery, etc.)			
Have you ever been told that your child has low iron?			
Does your child live in or regularly visit a house( or daycare facility) built before 1960?			
Does your family use pottery ware or lead crystal for cooking, eating or drinking?			
Has child been seen eating paint chips, crayons, or soil/dirt?			
Is child given any home or folk remedies that may contain lead (may include moonshine Azarcon, Greta, Paylocah)?			
Does your home's plumbing have lead pipes or copper pipes with lead solder joints?			

Please note: Lead level laboratory tests are mandatory at 12 and 24 months.

### Tuberculosis (Initiate @ one-year)

	Yes	No	Unsure
Has child been in close contact with a person with infectious tuberculosis?			
Does child have HIV infection or considered at risk for HIV infection?			
Is child foreign born (especially if born in Asia, Africa or Latin America), a refugee, or an immigrant?			
Is child in contact with the following individuals? HIV infected, homeless, nursing home residents, institutionalized or incarcerated adolescents or adults, illicit drug users, or migrant farm workers?			
Does child have a depressed immune system, either because of disease or treatment of disease?			
Does child live in an established "high risk for tuberculosis" community or area?			

### Cholesterol (Initiate @ two-years)

	Yes	No	Unsure
Does child have risk factors for future coronary disease such as physical inactivity, obesity, or Diabetes Mellitus?			
Is there a family history (parents and grandparents) of coronary or peripheral vascular disease below age 55?			
Is there a family history (parents and grandparents) of elevated blood cholesterol?			



Cookeville  
**Pediatric**  
Associates

**Smoking Questionnaire**

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Please answer the following questions.

1. Do you use tobacco products? Yes   
No

2. If you answered yes to the above question what type of tobacco products do you use?

Cigarettes

Smokeless Tobacco

Cigars

3. How often do you use tobacco products?

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4. Would you like to discuss treatment options for quitting with your doctor today?

Yes

No

## Pediatric Symptom Checklist 17 (PSC-17)

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Filled out by: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions, or learning, you may help your child get the best care possible by answering these questions. Please indicate which statement best describes your child. Please mark under the heading that best describes your child:

	Never	Sometimes	Often
◆ Fidgety, unable to sit still	0	1	2
■ Feels sad, unhappy	0	1	2
◆ Daydreams too much	0	1	2
● Refuses to share	0	1	2
● Does not understand other people's feelings	0	1	2
■ Feels hopeless	0	1	2
◆ Has trouble concentrating	0	1	2
● Fights with other children	0	1	2
■ Is down on him or herself	0	1	2
● Blames others for his or her troubles	0	1	2
■ Seems to have less fun	0	1	2
● Does not listen to rules	0	1	2
◆ Acts as if driven by a motor	0	1	2
● Teases others	0	1	2
■ Worries a lot	0	1	2
● Takes things that do not belong to him or her	0	1	2
◆ Distracted easily	0	1	2
Total ◆ _____ Total ● _____	◆ + ● + ■ = _____		
Total ■ _____			

\*The tool above is reprinted with permission of Michael Jellinek, MD, & J. Michael Murphy, EdD. This 17-item version was developed by W. Gardner & K. Kelleher.

Name: \_\_\_\_\_  
 DOB: \_\_\_\_\_  
 Date: \_\_\_\_\_

**PHQ9P**

PATIENT HEALTH QUESTIONNAIRE-9					72883
<b>THIS SECTION FOR USE BY STUDY PERSONNEL ONLY.</b>					
Were data collected? No <input type="checkbox"/> (provide reason in comments)					
If Yes, data collected on visit date <input type="checkbox"/> or specify date: _____					
Comments: _____					
<b>Only the patient (subject) should enter information onto this questionnaire.</b>					
Over the <u>last 2 weeks</u> , how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day	
1. Little interest or pleasure in doing things	0	1	2	3	
2. Feeling down, depressed, or hopeless	0	1	2	3	
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3	
4. Feeling tired or having little energy	0	1	2	3	
5. Poor appetite or overeating	0	1	2	3	
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3	
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3	
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3	
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3	
<b>SCORING FOR USE BY STUDY PERSONNEL ONLY</b> _____ + _____ + _____ + _____ =Total Score: _____					
If you checked off <u>any</u> problems, how <u>difficult</u> 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 <input type="checkbox"/>	Somewhat difficult <input type="checkbox"/>	Very difficult <input type="checkbox"/>	Extremely difficult <input type="checkbox"/>		
Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. Copyright © 2005 Pfizer, Inc. All rights reserved. Reproduced with permission. <span style="float: right;">EPI905.PHQ9P</span>					
I confirm this information is accurate.	Patient's/Subject's Initials:	Date:			

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## VACCINE INFORMATION STATEMENT

# HPV Vaccine Gardasil® (Human Papillomavirus)

## What You Need to Know

Many Vaccine Information Statements are available in Spanish and other languages. See [www.immunize.org/vis](http://www.immunize.org/vis)

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite [www.immunize.org/vis](http://www.immunize.org/vis)

### 1 What is HPV?

Genital human papillomavirus (HPV) is the most common sexually transmitted virus in the United States. More than half of sexually active men and women are infected with HPV at some time in their lives.

About 20 million Americans are currently infected, and about 6 million more get infected each year. HPV is usually spread through sexual contact.

Most HPV infections don't cause any symptoms, and go away on their own. But HPV can cause cervical cancer in women. Cervical cancer is the 2nd leading cause of cancer deaths among women around the world. In the United States, about 12,000 women get cervical cancer every year and about 4,000 are expected to die from it.

HPV is also associated with several less common cancers, such as vaginal and vulvar cancers in women, and anal and oropharyngeal (back of the throat, including base of tongue and tonsils) cancers in both men and women. HPV can also cause genital warts and warts in the throat.

There is no cure for HPV infection, but some of the problems it causes can be treated.

### 2 HPV vaccine: Why get vaccinated?

The HPV vaccine you are getting is one of two vaccines that can be given to prevent HPV. It may be given to both males and females.

This vaccine can prevent most cases of cervical cancer in females, if it is given before exposure to the virus. In addition, it can prevent vaginal and vulvar cancer in females, and genital warts and anal cancer in both males and females.

Protection from HPV vaccine is expected to be long-lasting. But vaccination is not a substitute for cervical cancer screening. Women should still get regular Pap tests.

### 3 Who should get this HPV vaccine and when?

*HPV vaccine is given as a 3-dose series*

1st Dose	Now
2nd Dose	1 to 2 months after Dose 1
3rd Dose	6 months after Dose 1

Additional (booster) doses are not recommended.

#### Routine vaccination

- This HPV vaccine is recommended for girls and boys 11 or 12 years of age. It *may* be given starting at age 9.

#### Why is HPV vaccine recommended at 11 or 12 years of age?

HPV infection is easily acquired, even with only one sex partner. That is why it is important to get HPV vaccine before any sexual contact takes place. Also, response to the vaccine is better at this age than at older ages.

#### Catch-up vaccination

This vaccine is recommended for the following people who have not completed the 3-dose series:

- Females 13 through 26 years of age.
- Males 13 through 21 years of age.

This vaccine *may* be given to men 22 through 26 years of age who have not completed the 3-dose series.

It is *recommended* for men through age 26 who have sex with men or whose immune system is weakened because of HIV infection, other illness, or medications.

HPV vaccine may be given at the same time as other vaccines.



U.S. Department of  
Health and Human Services  
Centers for Disease  
Control and Prevention

**4****Some people should not get HPV vaccine or should wait.**

- Anyone who has ever had a life-threatening allergic reaction to any component of HPV vaccine, or to a previous dose of HPV vaccine, should not get the vaccine. Tell your doctor if the person getting vaccinated has any severe allergies, including an allergy to yeast.
- HPV vaccine is not recommended for pregnant women. However, receiving HPV vaccine when pregnant is not a reason to consider terminating the pregnancy. Women who are breast feeding may get the vaccine.
- People who are mildly ill when a dose of HPV vaccine is planned can still be vaccinated. People with a moderate or severe illness should wait until they are better.

**5****What are the risks from this vaccine?**

This HPV vaccine has been used in the U.S. and around the world for about six years and has been very safe.

However, any medicine could possibly cause a serious problem, such as a severe allergic reaction. The risk of any vaccine causing a serious injury, or death, is extremely small.

Life-threatening allergic reactions from vaccines are very rare. If they do occur, it would be within a few minutes to a few hours after the vaccination.

Several mild to moderate problems are known to occur with this HPV vaccine. These do not last long and go away on their own.

- Reactions in the arm where the shot was given:
  - Pain (about 8 people in 10)
  - Redness or swelling (about 1 person in 4)
- Fever:
  - Mild (100° F) (about 1 person in 10)
  - Moderate (102° F) (about 1 person in 65)
- Other problems:
  - Headache (about 1 person in 3)
- Fainting: Brief fainting spells and related symptoms (such as jerking movements) can happen after any medical procedure, including vaccination. Sitting or lying down for about 15 minutes after a vaccination can help prevent fainting and injuries caused by falls. Tell your doctor if the patient feels dizzy or light-headed, or has vision changes or ringing in the ears.

Like all vaccines, HPV vaccines will continue to be monitored for unusual or severe problems.

**6****What if there is a serious reaction?****What should I look for?**

- Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or behavior changes.

Signs of a severe allergic reaction can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would start a few minutes to a few hours after the vaccination.

**What should I do?**

- If you think it is a severe allergic reaction or other emergency that can't wait, call 9-1-1 or get the person to the nearest hospital. Otherwise, call your doctor.
- Afterward, the reaction should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor might file this report, or you can do it yourself through the VAERS web site at [www.vaers.hhs.gov](http://www.vaers.hhs.gov), or by calling 1-800-822-7967.

*VAERS is only for reporting reactions. They do not give medical advice.*

**7****The National Vaccine Injury Compensation Program**

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines.

Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling 1-800-338-2382 or visiting the VICP website at [www.hrsa.gov/vaccinecompensation](http://www.hrsa.gov/vaccinecompensation).

**8****How can I learn more?**

- Ask your doctor.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call 1-800-232-4636 (1-800-CDC-INFO) or
  - Visit CDC's website at [www.cdc.gov/vaccines](http://www.cdc.gov/vaccines)

**Vaccine Information Statement (Interim)  
HPV Vaccine (Gardasil)**

5/17/2013

42 U.S.C. § 300aa-26

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# Bright Futures Patient Handout Early Adolescent Visits

## Your Growing and Changing Body

- Brush your teeth twice a day and floss once a day.
- Visit the dentist twice a year.
- Wear your mouth guard when playing sports.
- Eat 3 healthy meals a day.
- Eating breakfast is very important.
- Consider choosing water instead of soda.
- Limit high-fat foods and drinks such as candy, chips, and soft drinks.
- Try to eat healthy foods.
  - 5 fruits and vegetables a day
  - 3 cups of low-fat milk, yogurt, or cheese
- Eat with your family often.
- Aim for 1 hour of moderately vigorous physical activity every day.
- Try to limit watching TV, playing video games, or playing on the computer to 2 hours a day (outside of homework time).
- Be proud of yourself when you do something good.

PHYSICAL GROWTH AND DEVELOPMENT

## How You Are Feeling

- Figure out healthy ways to deal with stress.
- Spend time with your family.
- Always talk through problems and never use violence.
- Look for ways to help out at home.
- It's important for you to have accurate information about sexuality, your physical development, and your sexual feelings. Please consider asking me if you have any questions.

EMOTIONAL WELL-BEING

## School and Friends

- Try your best to be responsible for your schoolwork.
- If you need help organizing your time, ask your parents or teachers.
- Read often.
- Find activities you are really interested in, such as sports or theater.
- Find activities that help others.
- Spend time with your family and help at home.
- Stay connected with your parents.

SOCIAL AND ACADEMIC COMPETENCE

## Violence and Injuries

- Always wear your seatbelt.
- Do not ride ATVs.
- Wear protective gear including helmets for playing sports, biking, skating, and skateboarding.
- Make sure you know how to get help if you are feeling unsafe.
- Never have a gun in the home. If necessary, store it unloaded and locked with the ammunition locked separately from the gun.
- Figure out nonviolent ways to handle anger or fear. Fighting and carrying weapons can be dangerous. You can talk to me about how to avoid these situations.
- Healthy dating relationships are built on respect, concern, and doing things both of you like to do.

VIOLENCE AND INJURY PREVENTION

## Healthy Behavior Choices

- Find fun, safe things to do.
- Talk to your parents about alcohol and drug use.
- Support friends who choose not to use tobacco, alcohol, drugs, steroids, or diet pills.
- Talk about relationships, sex, and values with your parents.
- Talk about puberty and sexual pressures with someone you trust.
- Follow your family's rules.

RISK REDUCTION



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