MENTAL HEALTH QUESTIONNAIRE

Maryland Healthy Kids Program

Date__________

Child's Name: ________________________________ **Date of Birth:** ______________
Managed Care Organization: ______________________ **Child's Medicaid #:** ______________

Ages 13 – 20 years

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

Do you have trouble paying attention? .... ☐ Yes ☐ No

Do you often:
- Feel distrustful of others? .... ☐ Yes ☐ No
- Have strange thoughts? .... ☐ Yes ☐ No
- Hear voices? .... ☐ Yes ☐ No
- Have to do things the same way or keep repeating them? .... ☐ Yes ☐ No

Do you have problems at school with:
- Behavior? .... ☐ Yes ☐ No
- Grades? .... ☐ Yes ☐ No
- Skipping classes? .... ☐ Yes ☐ No

Do you worry about your:
- Eating? .... ☐ Yes ☐ No
- Sleep? .... ☐ Yes ☐ No
- Weight? .... ☐ Yes ☐ No

Do you have trouble making or keeping friends? .... ☐ Yes ☐ No

Do you often feel:
- Sad? .... ☐ Yes ☐ No
- Angry? .... ☐ Yes ☐ No
- Nervous or afraid? .... ☐ Yes ☐ No

Have you thought about or done any of the following:
- Destroy property? .... ☐ Yes ☐ No
- Hurt animals? .... ☐ Yes ☐ No
- Set fire? .... ☐ Yes ☐ No
- Listen to music with violent message? .... ☐ Yes ☐ No
- Use alcohol? .... ☐ Yes ☐ No
- Use drugs? .... ☐ Yes ☐ No
- Smoke cigarettes? .... ☐ Yes ☐ No
- Sex without protection? .... ☐ Yes ☐ No
- Suicide attempt? .... ☐ Yes ☐ No

Continued on back →

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 <u>Positive</u> 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: **<u>Maryland Public Mental Health System: 1-800-888-1965</u>**

Reason for Referral: ____

____

MARYLAND HEALTHY KIDS PROGRAM
Maryland Department of Health and Mental Hygiene
HealthChoice and Acute Care Administration, Division of Healthy Kids

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

TeenScreen® Primary Care

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

Source: Patient Health Questionnaire Modified for Teens (PHQ-9) (Author: Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues)

PC/PHQ-9 Mod/6.7.11/2000

A Survey From Your Healthcare Provider — PSC-Y

TeenScreen® Primary Care

Name	Date	ID

	Please mark under the heading that best fits you or circle Yes or No	Never 0	Sometimes 1	Often 2
-	1. Complain of aches or pains			
-	2. Spend more time alone			
-	3. Tire easily, little energy			
●	4. Fidgety, unable to sit still			
-	5. Have trouble with teacher			
-	6. Less interested in school			
●	7. Act as if driven by motor			
●	8. Daydream too much			
●	9. Distract easily			
-	10. Are afraid of new situations			
▲	11. Feel sad, unhappy			
-	12. Are irritable, angry			
▲	13. Feel hopeless			
●	14. Have trouble concentrating			
-	15. Less interested in friends			
■	16. Fight with other children			
-	17. Absent from school			
-	18. School grades dropping			
▲	19. Down on yourself			
-	20. Visit doctor with doctor finding nothing wrong			
-	21. Have trouble sleeping			
▲	22. Worry a lot			
-	23. Want to be with parent more than before			
-	24. Feel that you are bad			
-	25. Take unnecessary risks			
-	26. Get hurt frequently			
▲	27. Seem to be having less fun			
-	28. Act younger than children your age			
■	29. Do not listen to rules			
-	30. Do not show feelings			
■	31. Do not understand other people's feelings			
■	32. Tease others			
■	33. Blame others for your troubles			
■	34. Take things that do not belong to you			
■	35. Refuse to share			
◆	36. During the past three months, have you thought of killing yourself?		Yes	No
◆	37. Have you ever tried to kill yourself?		Yes	No

● = A ≥ 7 ▲ = I ≥ 5 ■ = E ≥ 7 | Note — the sub scores do not impact the overall score; they are for interpretation purposes only.

TS ______________

FOR OFFICE USE ONLY

Plan for Follow-up ☐ Annual screening ☐ Return visit w/ PCP ☐ Referred to counselor
☐ Parent declined ☐ Already in treatment ☐ Referred to other professional

Q 36 or Q 37=Y ◆ TS ≥ 30

Source: Pediatric Symptom Checklist – Youth Report (PSC-Y)

MARYLAND HEALTHY KIDS PROGRAM

Preventive Screen Questionnaire

Anemia Screening (Starting at 11 years of age and annually thereafter)	Date ___	Date ___	Date ___	Date ___	Date ___	Date ___	Date ___
1. (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
2. (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
3. (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
4. (FEMALES ONLY) Does your period last more than 5 days?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N

Heart Disease/Cholesterol Risk Assessment: *(2 years through 20 years)*	Date ___	Date ___	Date ___	Date ___	Date ___	Date ___	Date ___
1. 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
2. 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
3. Is the child/adolescent overweight (BMI > 85th %)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
4. And is there a personal history of:							
Smoking?	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
High blood pressure?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
High cholesterol?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Diabetes mellitus?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N

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

STI/HIV Risk Assessment: *(11 years through 20 years)*	Date ___	Date ___	Date ___	Date ___	Date ___	Date ___	Date ___
1. Are you sexually active?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
2. If sexually active, have you had more than one partner?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
3. 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
4. Have you ever been sexually molested or physically attacked?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
5. Have you ever been diagnosed with any sexually transmitted diseases?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
6. 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
7. 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
8. 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

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

Lead Risk Assessment: *(every well child visit from 6 months up to 6 years)*	**Date**	**Date**	**Date**	**Date**	**Date**	**Date**	**Date**
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
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
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
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
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
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
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? **Examples:** Glazed pottery, Greta, Azarcon (Rueda, Coral, Liga), Litargirio, Surma, Kohl (Al kohl), Pay-loo-ah, Ayurvedic medicine, Ghassard).	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N

Tuberculosis Risk Assessment: *(Starting at 1 month, 6 months of age and annually thereafter)*	**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
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
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
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
5. Does your child have HIV infection?	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:** ____________

CRAFFT

TeenScreen® Primary Care

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

Name ______________________________

Medical Record or ID Number ______________________ Date ______________

Part A

During the PAST 12 MONTHS, did you:

	No		Yes	
1. Drink any alcohol (more than a few sips)?	☐	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.
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"	☐		☐	

Part B

	No	Yes
1. Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	☐	☐
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?	☐	☐

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Programa para Niños Saludables de Maryland/Maryland Healthy Kids Program

Maryland Department of Health and Mental Hygiene
Division of Healthy Kids

Día del servicio:___________

Nombre del Paciente:______________ Fecha de Nacimiento:__________

Evaluación de Uso de Substancias en Adolescentes

Si el paciente/cliente acepta haber usado drogas o alcohol, haga las siguientes preguntas:

C –¿Te has subido en algún CARRO/COCHE con alguien (incluyéndote a ti) que haya estado bajo los efectos del alcohol o drogas?

☐ S ☐ N

R – ¿Alguna vez has usado alcohol o drogas para RELAJARTE, sentirte mejor contigo mismo o para ser aceptado por otros?

☐ S ☐ N

S – ¿Has usado alcohol o drogas estando SOLO?

☐ S ☐ N

O – ¿Has OLVIDADO cosas que has hecho mientras usabas alcohol o drogas? ☐ S ☐ N

A – ¿En algún momento familiares o AMIGOS te han dicho que debes disminuir tu uso de alcohol o drogas?

☐ S ☐ N

P – ¿Te has metido en PROBLEMAS mientras usabas alcohol o drogas?

☐ S ☐ N

Haga un referido si el paciente/cliente a contestado que sí a alguna de estas preguntas. **Comuníquese con la Organización de Cuidado Dirigido/ Organización para servicios de tratamiento de abuso de substancias. Chequée la sección del manual para los números de autorización y notificación.**

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Para más información, comuníquese con info@CRAFFT.org, o visite al www.crafft.org

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

Name of Hospital: ____________

Illnesses during pregnancy? No ☐ Yes ☐

Medications during pregnancy? No ☐ Yes ☐

Alcohol/Drug Abuse? No ☐ Yes ☐

Problems at birth? No ☐ Yes ☐

Describe: ____________

Type of delivery? ☐ Vaginal ☐ C-section

Birth Weight__________Discharge Weight_____

Did baby receive Hepatitis B vaccine? No ☐ Yes ☐

Date of Hepatitis B immunization:__________

Newborn Hearing Screen? No ☐ Yes ☐

PSYCHOSOCIAL HISTORY

Who lives in household?____________

____

How many?_____

☐ Rent? ☐ Own? ☐ Shelter?

Who cares for child?____________

Date of Birth? Mother____________

Father____________

Are parents working? Mother No ☐ Yes ☐

Father No ☐ Yes ☐

Foster Care? __________Dates:__________

Other Languages?____________

FAMILY HISTORY

Has anyone in the family (parents, grand-parents, aunts/uncles, sisters/brothers) had:

	No	Yes	Who?
Allergies (List) ____________	No ☐	Yes ☐	_____
Asthma	No ☐	Yes ☐	_____
TB/Lung Disease	No ☐	Yes ☐	_____
HIV/AIDS	No ☐	Yes ☐	_____
Suicide Attempts	No ☐	Yes ☐	_____
Heart Disease	No ☐	Yes ☐	_____
High Blood Pressure/Stroke	No ☐	Yes ☐	_____
High Cholesterol	No ☐	Yes ☐	_____
Blood Disorders/Sickle Cell	No ☐	Yes ☐	_____
Diabetes	No ☐	Yes ☐	_____
Seizures	No ☐	Yes ☐	_____
Mental Illness	No ☐	Yes ☐	_____
Cancer	No ☐	Yes ☐	_____
Birth Defects	No ☐	Yes ☐	_____
Hearing Loss	No ☐	Yes ☐	_____
Speech Problems	No ☐	Yes ☐	_____
Kidney Disease	No ☐	Yes ☐	_____
Alcohol/Drug Abuse	No ☐	Yes ☐	_____
Hepatitis/Liver Disease			
Thyroid Disease	No ☐	Yes ☐	_____
Learning Problems/Attention	No ☐	Yes ☐	_____
Deficit Disorder	No ☐	Yes ☐	_____
Family Violence	No ☐	Yes ☐	_____

Other: ____________

MEDICAL HISTORY

Has your child ever had:

	No	Yes
Allergies (List) ____________	No ☐	Yes ☐
Asthma	No ☐	Yes ☐
Chicken Pox (Year) ____	No ☐	Yes ☐
Frequent Ear Infections	No ☐	Yes ☐
Vision/Hearing Problems	No ☐	Yes ☐
Skin Problems/Eczema	No ☐	Yes ☐
TB/Lung Disease	No ☐	Yes ☐
Seizures/Epilepsy	No ☐	Yes ☐
High Blood Pressure	No ☐	Yes ☐
Heart Defects/Disease	No ☐	Yes ☐
Liver Disease/Hepatitis	No ☐	Yes ☐
Diabetes	No ☐	Yes ☐
Kidney Disease/Bladder Infections	No ☐	Yes ☐
Physical or Learning Disabilities	No ☐	Yes ☐
Bleeding Disorders/Hemophilia	No ☐	Yes ☐
Sexually Transmitted Diseases	No ☐	Yes ☐
Emotional or Behavioral Problems	No ☐	Yes ☐
Depression/Suicidal Thoughts	No ☐	Yes ☐
Hospitalizations/Surgeries	No ☐	Yes ☐
Physical/Emotional/ Sexual Abuse	No ☐	Yes ☐
Bone or Joint Injuries	No ☐	Yes ☐
Obesity/Eating Disorders	No ☐	Yes ☐
Other: ____________	No ☐	Yes ☐

Current Medication(s): (*List*) ____________

Reviewed by:	Date of Review:

Maryland Healthy Kids Program
Cuestionario de Historial Médico Familiar

Nombre del Paciente:	Fecha de Nacimiento:	Sexo: M F (circule)
Persona que llenó el Formulario: / Fecha de Hoy:	Relación con el Paciente::	

HISTORIAL DURANTE EMBARAZO Y AL NACER

Nombre del Hospital: ____________

Enfermedades durante el embarazo No ☐ Si☐

Medicamentos durante embarazo No ☐ Si☐

Abuso de Alcohol o drogas No ☐ Si☐

Problemas al Nacer No ☐ Si☐

Describa: ____________

Tipo de Parto ☐ Vaginal ☐ Cesárea

Peso al Nacer______Peso al darle de alta_______

El bebé recibió vacuna para Hepatitis B No☐ Si ☐

Fecha de la vacuna de Hepatitis B:____________

Examen Auditivo para recien nacidos No ☐ Si ☐

HISTORIAL PSICOSOCIAL

¿Quién vive en el hogar?____________

____

¿Cuántas personas viven en el hogar?______

☐ Alquilan ☐ casa propia ☐ refugio

¿Quién cuida el niño/a?____________

Fecha de Nacimiento Madre____________

Padre____________

Trabajan los Padres Madre No ☐ Si ☐

Padre No ☐ Si ☐

Hogar Sustituto __________ Fecha:__________

¿Qué otro idiomas se hablan en la casa?__________

____

HISTORIAL FAMILIAR

Hay alguien en la familia (padres, abuelos, tíos/as, hermanos/as) que haya tenido:

	No	Si	¿Quién?
Alergias (a qué) ____________	☐	☐	______
Asma	☐	☐	______
TB/Enfermedad del Pulmón	☐	☐	______
VIH/SIDA	☐	☐	______
Intentos Suicidas/Problemas	☐	☐	______
Mentales	☐	☐	______
Enfermedad del Corazón	☐	☐	______
Presión alta/Derrame	☐	☐	______
Colesterol Alto	☐	☐	______
Desórdenes de la	☐	☐	______
Sangre/"Sickle Cell"	☐	☐	______
Diabetes	☐	☐	______
Convulsiones	☐	☐	______
Alergias/Asma	☐	☐	______
Desórdenes Mentales	☐	☐	______
Cáncer	☐	☐	______
Defectos de Nacimiento	☐	☐	______
Pérdida de Audición	☐	☐	______
Problemas de habla	☐	☐	______
Enfermedades Renales	☐	☐	______
Abuso de Alcohol/ Droga	☐	☐	______
Hepatitis/Enfermedad del	☐	☐	______
Hígado	☐	☐	______
Enfermedad de la Tiroide	☐	☐	______
Problemas de Aprendizaje/	☐	☐	______
Deficit de Atención ("ADD")	☐	☐	______
Violencia Doméstica			

Otras:____________

HISTORIAL DE SALUD

Alguna vez su niño/a ha tenido:

Alergias (a qué)____________

	No	Si
Asma	☐	☐
Varicela (año) _______	☐	☐
Infecciones frecuentes de oído	☐	☐
Problemas de Audición/Infecciones	☐	☐
de la Vista	☐	☐
Problemas de la Piel/Eczema	☐	☐
Asma/Alergias	☐	☐
TB/Enfermedad del Pulmón	☐	☐
Convulsiones/Epilepsia	☐	☐
Hipertensión/Presión Alta	☐	☐
Enfermedad del Corazón/Defectos	☐	☐
Hepatitis/Enfermedad del Hígado	☐	☐
Diabetes	☐	☐
Enfermedades del Riñón/Vejiga	☐	☐
Problemas Físicos o de Aprendizaje	☐	☐
Desórdenes de la Sangre/Hemofilia	☐	☐
Enfermedades Transmitidas Sexualmente	☐	☐
Problemas Emocionales o de Comportamiento	☐	☐
Depresión/Pensamientos Suicidas	☐	☐
Hospitalizaciones/Cirugías	☐	☐
Abuso /Físico/Emocional/ o Sexual	☐	☐
Problemas en las Coyunturas/Huesos	☐	☐
Obesidad/Trastornos Alimenticios	☐	☐

Otras: ____________

Lista de Medicamento/s que toma:____________

Revisado por:	Fecha que fue Revisado:

Updated: 4/06