clinical
pediatric
associates

J. PATRICK HIEBER, M.D., D.A.B.P.

11+ every check-up

Pediatric TB Risk Assessment Questionnaire

Name of Child: _____ Child's Date of Birth: _____ Date of Screening: _____

Questions for Parent/Guardian	Follow-up
1. ***Were you or your child born outside of the United States?*** Yes □ No □ If yes: Where were you and/or your child born? _____	If the parent or child was born in Africa, Asia, Latin America, or Eastern Europe, a TST or IGRA should be placed.
2. ***Has your child traveled outside of the United States?*** Yes □ No □ If yes: Where did your child travel? _____ How long was your child outside the United States? _____	If the child stayed with friends or family members in Africa, Asia, Latin America, or Eastern Europe for 1 week cumulatively, a TST or IGRA should be placed.
3. ***To your knowledge, has your child been exposed to anyone with TB disease?*** Yes □ No □ If yes: Did the person have TB disease or LTBI? Yes □ No □ When did the exposure occur? _____ What was the nature of the contact? _____	If confirmed that the child has been exposed to an individual with suspected or known TB disease, a TST or IGRA should be placed.
4. ***To your knowledge, has your child had close contact with a person who has had a positive TB skin test?*** Yes □ No □ If yes: Did the person have TB disease or LTBI? Yes □ No □ When did the exposure occur? _____ What was the nature of the contact? _____	If confirmed that the child has close contact with an individual with a positive skin test, a TST or IGRA should be placed.

clinical
pediatric
associates

J. PATRICK HIEBER, M.D., D.A.B.P.

11+ every year

Patient Name: _____ Age: _____

Date of Birth: _____ Today's Date: _____

THIS FORM TO BE COMPLETED BY THE PATIENT BEFORE SEEING DR. HIEBER.

1. Would you like time to meet with Dr. Hieber without your parents present during this visit? **YES NO**

2. Has there been any changes in your health/home/school situation since your last visit? **YES NO**

3. Any concerns about drugs, sex, alcohol, or violence at home or school? **YES NO**

4. For Females Only

Approximate date of onset of periods _____

Are you periods regular? **YES NO**

If not, what is the average pattern? _____

5. School

How is school? _____

Grades? _____

Homework? _____

Are you able to stay focused at school? _____

6. Nutrition Information

Do you have meals together as a family? **YES NO**

Regular meals with variety and adequate fruits/vegetables? **YES NO**

Do you drink sodas or sweetened beverages? **YES NO**

If so, how many per day _____

Do you have a source of calcium such as milk or dairy? **YES NO**

Do you have any concerns about your body or appearance? **YES NO**

7. Activities

Do you have friends? **YES NO**

Do you have at lease one hour of physical activity per day? **YES NO**

Approximately how much screen time do you have per day? _____

Are you involved in any sports? _____

Are you involved in any art or musical activities? _____

Do you participate in any community/volunteer activities? _____

8. Mental Health

Do you have a way of coping with stress? **YES NO**

Are you allowed to make independent decisions? **YES NO**

Do you feel self-confident? **YES NO**

Do you have troubles sleeping? **YES NO**

Do you ever experience mood swings or anger? **YES NO**

clinical
pediatric
associates

J. PATRICK HIEBER, M.D., D.A.B.P.

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these 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 _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

clinical
pediatric
associates

J. PATRICK HIEBER, M.D., D.A.B.P.

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**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

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, 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**
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.