Dr. med. Claus Bode
Kinderarzt
allergologe
Jugendsprechstunde

Sternstrasse 74
40479 Düsseldorf
Tel.: 0211 - 49 04 36

# Questionnaire for the Youth Check-up J1



I would like to ask you some questions regarding yourself and your health. Your answers will be of great help while we carry out your check up.

| | Yes | No |
|---|---|---|
| Do you regularly/sometimes suffer from symptoms such as headache, fatigue, concentration difficulties, dizziness, stomach ache, back/joint aches, other? | ❍ | ❍ |
| Do you have problems with gross motor skills?<br>Do you have difficulties for example when playing ball games, running, cycling, climbing and swimming or during/after exercise classes? | ❍ | ❍ |
| Do you have problems with fine motor skills? Do you like painting and crafts less than your peers? Are you poor at writing and unskilled at handicrafts? | ❍ | ❍ |
| Do you experience learning difficulties? Do you have difficulties learning things by heart, concentrating, reading, calculating and writing? | ❍ | ❍ |
| Which type of school do you go to? Hauptschule/Realschule/Gymnasium<br>Class:<br>Average grade:<br>Are you in danger of not moving up a grade?<br>Favourite subjects:<br>Difficult subjects: | ❍ | ❍ |
| Are you happy at school? | ❍ | ❍ |
| Are you able to stick to the rules? | ❍ | ❍ |
| Are you generously helpful? | ❍ | ❍ |
| Do you have friends of the same age (your “gang”)? | ❍ | ❍ |
| Do you behave differently at home than at school? | ❍ | ❍ |
| Do you suffer from eating disorders, nervous twitches or obsessive compulsive disorders? | ❍ | ❍ |
| Are you usually happy and well-balanced? | ❍ | ❍ |
| Do you have enough successes at school and out of school? | ❍ | ❍ |
| Do you approach assigned tasks intensively, ambitiously and willingly? | ❍ | ❍ |
| Are you afraid of anything (at school, at home, in your free time)? | ❍ | ❍ |
| Do you regularly take medication? If so which? | ❍ | ❍ |
| Has a doctor subscribed iodine prophylaxis or thyroid hormone therapy? | ❍ | ❍ |
| Do you smoke? | ❍ | ❍ |
| Do you drink alcohol? | ❍ | ❍ |
| Have you ever taken drugs? | ❍ | ❍ |

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# Questionnaire for the Youth Check-up J1



| | Yes | No |
|---|---|---|
| Do you do sports? If so, in a club or with friends in your free time? | ❍ | ❍ |
| What are your hobbies? | | |
| How many hours a day/hours at the weekend do you watch TV? | | |
| How many hours a day do you play computer games? | | |
| How many hours a day do you listen to music? | | |
| Do you read books, magazines or comics? | ❍ | ❍ |
| What do you do in the evenings? Are you member in a youth club or any association? Do you go to a youth centre? | ❍ | ❍ |
| | | |
| Do you have any dietary problems? If so which? | ❍ | ❍ |
| Do you have any special dietary habits (such as vegetarianism)? | ❍ | ❍ |
| Puberty: | | |
| My first menstruation was at ..... (age). | | |
| I have a regular/irregular menstruation. | ❍ | ❍ |
| When was your last menstruation? | | |
| Has your voice broken yet? | ❍ | ❍ |
| Do you suffer from sexual problems? | ❍ | ❍ |
| | | |
| Would you like to discuss anything specific with me? | ❍ | ❍ |
| | | |
| Thank you for taking the time to answer these questions. Please bring this questionnaire, your certificate of vaccination and your check up booklet to your appointment. This will be of great help for the J1. Please remember that the check up will require you to concentrate for one hour. Therefore, please come alone, without siblings and look forward to your appointment in spite of all these questions!<br><br>Your doctor | | |

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# Questionnaire for parents



Patient's Name: .....

Dear parents

With this questionnaire I would like to ask you a few important questions about your child. Your answers make it easier to carry out the check-up and provide important information for me. Please bring this questionnaire to the check-up. If there are aspects that you are interested in or worry you, I will certainly answer all your questions. Dear parents

| Health Problems | Yes |
|---|---|
| Does your child or any other family member suffer from one of the following conditions? | |
| Allergies, asthma, hay fever, eczema, shortness of breath at rest or during physical exertion? | ❍ |
| Pain (i.e. headache/migraine, stomach, back, hip, knees)? If so, where? _____ How frequently? Daily/ once a week/once a month/during the day/during the night/after physical exertion. | ❍ |
| Heart attack, suffered from circulatory problems or lipid metabolism problems (cholesterol)? | |
| Frequent or long lasting infections or chronic diseases? | ❍ |
| Impaired hearing or vision, squinting? | ❍ |
| Illness of the thyroid gland, high blood pressure, kidney or blood diseases? Is your child overweight? | ❍ |
| Sudden cramp attacks (i.e. febrile convulsions)? Psychological complaints? | ❍ |
| Physical handicaps (i.e. of the musculoskeletal system)? | ❍ |
| Problems which occurred during pregnancy or birth? (age). | ❍ |
| Problems while beginning to walk, in speech development, during kindergarten? | ❍ |
| Were therapies necessary (i.e. physiotherapy, speech therapy, ergotherapy, psychotherapy)?<br>Did your child suffer from development-inhibiting diseases or has it undergone operations since the last medical check-up? If so, which? _____ | ❍ |
| | |
| Have you observed psychological development problems or behavioural disturbances in your child? | ❍ |
| Does your child still wet itself during the day/at night (urine/stool)? | ❍ |
| Does your child have significant problems falling asleep or sleeping through the night? | ❍ |
| Are you worried because your child often gets into trouble with other children or adults? | ❍ |
| Is your child overaggressive? | ❍ |
| Does your child have any fears? If so, of what or whom? | ❍ |
| Have you observed any emotional problems such as depressions? | ❍ |
| Does your child enjoy playing with its peers or does it not play with them at all? | ❍ |
| Does your child have difficulties concentrating, is he or she physically overactive? | ❍ |
| Does your child lack stamina or attention while learning or playing? | ❍ |

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# Questionnaire for parents



| Health Problems | Yes |
|---|---|
| Is your child sufficiently vaccinated? Please bring the relevant documents to the check-up! | ❍ |
| Does your child regularly take iodine pills or thyroid hormones? | **No** ❍ |
| Heart attack, suffered from circulatory problems or lipid metabolism problems (cholesterol)? | |
| Frequent or long lasting infections or chronic diseases? | ❍ |
| Impaired hearing or vision, squinting? | ❍ |
| Illness of the thyroid gland, high blood pressure, kidney or blood diseases? Is your child overweight? | ❍ |
| Sudden cramp attacks (i.e. febrile convulsions)? Psychological complaints? | ❍ |
| Physical handicaps (i.e. of the musculoskeletal system)? | ❍ |
| Problems which occurred during pregnancy or birth? (age). | ❍ |
| Problems while beginning to walk, in speech development, during kindergarten? | ❍ |
| Were therapies necessary (i.e. physiotherapy, speech therapy, ergotherapy, psychotherapy)?<br>Did your child suffer from development-inhibiting diseases or has it undergone operations since the last medical check-up? If so, which? _____ | ❍ |
| **Family** | |
| Mother's Occupation _____ | |
| Father's Occupation _____ | |
| Single parent | ❍ |
| Divorced | ❍ |
| Mother smoker | ❍ |
| Father smoker | ❍ |
| Size of home _____ m2 | |
| Number of rooms _____ | |
| Own room | ❍ |
| **Educational Development** | |
| Are you worried about the educational development of your child? | ❍ |
| Does he or she have any problems with certain teachers? If so, which? _____ | ❍ |
| Have other problems occurred at school (i.e. violence, alcohol, drugs, or problems relating to homework, being over or under challenged, concentration problems, restlessness, behavioural problems)? | ❍ |

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# Questionnaire for parents



| Health | Yes |
|---|---|
| Does your child regularly take over the counter medication? | ❍ |
| Does he or she smoke nicotine _____, drink alcohol ____ or take drugs ____? | ❍ |
| **Psychological Development** | |
| Are you worried about the development or the behaviour of your child? (i.e. family structure, diet, leisure activities, standing among friends, hobbies, state of physical/mental/psychological/sexual development) If so, which? _____ | ❍ |