Well Child Check: 12-17 year visit questionnaire

Interval History:
Have you had any major illnesses, ER or Urgent Care trips since your last appointment in the office? No Yes
Have you had any reactions to vaccinations in the past? No Yes

School/Activities/Employment:
What school do you attend? _______________________
What grade are you in? ___________________________
Are you or is anyone concerned about your grades? No Yes
Are you employed? No Yes
If so, where? ___________________________________________
What activities do you participate in (music/arts/sports/other)? _________________________
_____________________________________________________________________________

How many hours of “screen time” do you watch per day (including TV, computers, tablets, videogames, cell phone)? __________________

For Girls Only:
Have you had your first period? Yes No
Are your periods irregular or heavy? No Yes
Do you have any questions about your periods? No Yes

Vision/Hearing:
Do you have any concerns about how you hear? No Yes
Do you have any problems seeing far away or close up? No Yes

Physical Activity:
Do you exercise or play sports most days of the week? Yes No
Do you have any chest pain, dizziness or fainting with exercise? No Yes
Have you ever had an irregular heartbeat or palpitations? No Yes
Have you ever had a seizure or loss of consciousness? No Yes
Have you ever had a concussion or head injury? No Yes
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<thead>
<tr>
<th>Question</th>
<th>No</th>
<th>Yes</th>
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<tbody>
<tr>
<td>Have you ever had heat exhaustion or heat stroke?</td>
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<td>Are you missing a kidney, testicle, eye or any organ?</td>
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<td>Do you use an inhaler for asthma, cough or sports?</td>
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<tr>
<td><strong>Dental Health:</strong></td>
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<tr>
<td>Do you brush and floss your teeth daily?</td>
<td>Yes</td>
<td>No</td>
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<td>Do you see a dentist regularly (twice a year)?</td>
<td>Yes</td>
<td>No</td>
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<td><strong>Staying Healthy/Safety/Tobacco Exposure:</strong></td>
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<td>Does your home have a working smoke detector?</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Does your home have the number of the Poison Control Center</td>
<td></td>
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<td>(800-222-1222) posted by your phone?</td>
<td>Yes</td>
<td>No</td>
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<td>Do you always wear a seat belt when in the car?</td>
<td>Yes</td>
<td>No</td>
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<td>Do you know how to swim?</td>
<td>Yes</td>
<td>No</td>
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<td>Do you use sunscreen/hat/other sun protection measures when you</td>
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<td>are outdoors?</td>
<td>Yes</td>
<td>No</td>
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<td>Do you spend time in a home where a gun is kept?</td>
<td>No</td>
<td>Yes</td>
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<td>If so, are all guns safely stored in a gun safe or locked</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
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<td>with ammunition separate from gun?</td>
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<td>Do you spend time with anyone who carries a gun, knife, or other weapon?</td>
<td>No</td>
<td>Yes</td>
<td>Skip</td>
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<td>If so, is the weapon safely stored and inaccessible?</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
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<td>Do you wear a helmet when riding a bike, skateboard or scooter?</td>
<td>Yes</td>
<td>No</td>
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<td>Have you ever witnessed abuse or violence?</td>
<td>No</td>
<td>Yes</td>
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<td>Have you been hit, slapped, kicked, or physically hurt by someone</td>
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<td>(or have you hurt someone) in the past year?</td>
<td>No</td>
<td>Yes</td>
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<td>Have you ever been bullied or felt unsafe at school or in your</td>
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<td>neighborhood (or been cyber-bullied)?</td>
<td>No</td>
<td>Yes</td>
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<td>Do you spend time with anyone who smokes?</td>
<td>No</td>
<td>Yes</td>
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<td><strong>Tuberculosis Screening:</strong></td>
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<td>Has a family member or contact had tuberculosis or a positive</td>
<td>Yes</td>
<td>No</td>
<td>Unsure</td>
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<td>tuberculin skin test (PPD)?</td>
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Were you born in a high risk country (countries other than the US, Canada, Australia, New Zealand or Western Europe)?  
No  Yes

Have you traveled to (or had contact with people who live in a high risk country) for more than one week?  
(Countries other than the US, Canada, Australia, New Zealand or Western Europe)  
No  Yes

Risk Assessment for Abnormal Lipid Profile (such as high cholesterol):
Did any of your parents or grandparents have significant heart disease at or before 55 years of age (heart attack, stroke, angioplasty, angina or bypass surgery?)?  
No  Yes  Unsure

Do either of your parents have a cholesterol of 240 or higher?   
No  Yes  Unsure

Sleep:
How many hours do you sleep at night?       ___ hours
Are you satisfied with your sleep?      Yes  No

Nutrition:
What type of milk do you drink? (circle one)  [Whole]  [2%]  [Nonfat]  [Other]  [None]  

How many ounces of milk do you drink per day?   ___ oz

How much juice/soda/sports/energy drinks do you drink each day?    ___ oz

Are you eating fruits and vegetables at least two times per day?  
Yes  No

Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, soy milk, cheese, yogurt, or tofu?  
Yes  No

Do you eat high fat foods such as fried foods, chips, ice cream or pizza more than once per week?      No  Yes

Do you eat iron rich foods (such as meat, eggs, iron-fortified cereals or beans)?  
Yes  No

Do you eat a strict vegetarian diet?  
No  Yes

If you are a vegetarian, do you take an iron supplement?  
Yes  No  N/A

Are you happy about your weight?      Yes  No

Are you trying to gain or lose weight currently?  
No  Yes
Patient Name/Date of Birth________________________________________________

Please list any medications or supplements you take:
___________________________________________________________________________________________

Who do you live with? ________________________________________________________________________

Please list any new major family medical issues:
___________________________________________________________________________________________

Please list any known medicine allergies: _________________________________________________________

Please list any known food allergies: _____________________________________________________________

Do you have any concerns you would like to discuss with your provider?
___________________________________________________________________________________________

Signature: ___________________________________________________ Date: __________________

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<th>Clinic Use Only</th>
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☐ Patient Declined the SHA

PCP’s Signature  Print Name:  Date:

Ver.5-7-15
Mental Health/Sexual Health/Substance Exposure

THE ANSWERS TO THESE QUESTIONS ARE CONFIDENTIAL

During the past 2 weeks, how often have you been bothered by the following problems:

Feeling down, depressed, irritable, or hopeless?
- [Not at all]
- [Several days]
- [More than half the days]
- [Nearly every day]

Little interest or pleasure in doing things?
- [Not at all]
- [Several days]
- [More than half the days]
- [Nearly every day]

During the past 12 months, did you:

- Drink any alcohol (more than a few sips)?
- Smoke any marijuana or hashish?
- Use anything else to get “high”?
  - (“Anything else” includes illegal drugs, over-the-counter and prescription drugs, and things that you sniff or “huff”.)
- Have you ever ridden in a car driven by someone (including yourself) who was “high” or had been using alcohol or drugs?
- Do you smoke cigarettes or chew tobacco?
- Do you use medicines not prescribed for you?
- Do you have friends or family members who have a problem with drugs or alcohol?
- Have you ever been forced or pressured to have sex?
- Have you ever had sex (including intercourse or oral sex)?
  - If “no”, you can skip the following questions:
    - Do you think your partner could have a sexually transmitted infection, such as Chlamydia, Gonorrhea, Genital warts?
    - Have you or your partner(s) had sex with other people in the past year?
    - Have you or your partner(s) had sex without using birth control in the past year?
    - The last time you had sex, did you use birth control?
    - Have you or your partner(s) had sex without a condom in the past year?
    - Did you or your partner use a condom the last time you had sex?
- Do you have any questions about your sexual orientation (who you are attracted to) or gender identity (how you feel as a boy, girl, or other gender)?

End of confidential section