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?
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
Have you ever had heat exhaustion or heat stroke? No Yes
Are you missing a kidney, testicle, eye or any organ? No Yes
Do you use an inhaler for asthma, cough or sports? No Yes

**Dental Health:**
Do you brush and floss your teeth daily? Yes No
Do you see a dentist regularly (twice a year)? Yes No

**Staying Healthy/Safety/Tobacco Exposure:**
Does your home have a working smoke detector? Yes No
Does your home have the number of the Poison Control Center (800-222-1222) posted by your phone? Yes No
Do you always wear a seat belt when in the car? Yes No
Do you know how to swim? Yes No
Do you use sunscreen/hat/other sun protection measures when you are outdoors? Yes No
Do you spend time in a home where a gun is kept? No Yes Skip
  If so, are all guns safely stored in a gun safe or locked with ammunition separate from gun? Yes No N/A
Do you spend time with anyone who carries a gun, knife, or other weapon? No Yes Skip
  If so, is the weapon safely stored and inaccessible? Yes No N/A
Do you wear a helmet when riding a bike, skateboard or scooter? Yes No
Have you ever witnessed abuse or violence? No Yes
Have you been hit, slapped, kicked, or physically hurt by someone (or have you hurt someone) in the past year, other than occasional sibling or friend roughness? No Yes
Have you ever been bullied or felt unsafe at school or in your neighborhood (or been cyber-bullied)? No Yes
Do you spend time with anyone who smokes? No Yes

**Tuberculosis Screening:**
Were you born in a country with an elevated TB rate? No Yes
  This includes all countries *other than* the United States, Canada, Australia, New Zealand, or countries in western or northern Europe.
Have you visited or lived in a country with an elevated TB rate for one month or more? (Countries other than those listed above) No Yes

Have you had contact with someone (including family member, childcare provider, or other caretaker) with known TB infection, or who has been treated for TB infection? No Yes Unsure

Are you immunosuppressed (currently or planned)? This includes HIV infection, organ transplant recipient, other immune system problems, or treatment with immunosuppressive medications. 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

If yes, who? at what age? 

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

If yes, who? How high (before treatment)?

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

Does you eat junk foods such as chips, fries, ice cream or fast food more than twice 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

Elimination:

Does you have bowel movements on a regular basis with
a normal (soft) consistency?  Yes   No

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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PCP’s Signature  Print Name:  Date:  ____________________

[ ] Patient Declined the SHA

Ver.12-12-17