# Well Adult Check: 18-21 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/year are you in school?  

Are you concerned about your grades?  
No  Yes

Are you employed?  
No  Yes

If so, where?  

What activities do you participate in (music/arts/sports/other)?  

## For Women Only:
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 spend time doing activities, such as walking, gardening, or swimming for ½ hour a day?  
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/Mental Health/Tobacco, Alcohol, Drug Use / Sexual Health:

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

Have you had any car accidents lately?  
No  Yes  Skip

Do you swim?  
Yes  No

Do you use sunscreen/hat/other sun protection measures when you are outdoors?  
Yes  No

Do you keep a gun in your house or place where you live?  
No  Yes  Skip

If so, is it safely stored in a gun safe or locked with ammunition separate from gun?  
Yes  No  N/A

Have you been hit, slapped, kicked, or physically hurt by someone in the past year?  
No  Yes  Skip

Do you feel safe where you live?  
Yes  No

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]

Do friends/family members smoke in your house/place where you live?  
No  Yes

Do you smoke cigarettes or chew tobacco?  
No  Yes

Do you use or sniff any substance to get high, such as marijuana, cocaine, crack, methamphetamine (meth), ecstasy, etc?  
No  Yes  Skip

Do you use any drugs or medicines to help you sleep, relax, calm down, feel better or lose weight?  
No  Yes  Skip

Do you drink alcohol?  
No  Yes  Skip

*If “yes”, please answer the following questions. If “no”, you can skip to the next unrelated question.*

--Do you drink enough to get drunk or pass out?  
No  Yes  Skip

--In the past year, have you had:

For Men, 5 or more alcohol drinks in one day?  
No  Yes  Skip

For Women, 4 or more alcohol drinks in one day?  
No  Yes  Skip

--Do you drive a car after drinking?  
No  Yes  Skip
Do you ride in a car with someone who has been drinking alcohol or using drugs?  
No ☐ Yes ☐ Skip ☐

Have you ever had sex (including intercourse or oral sex)?  
No ☐ Yes ☐ Skip ☐

*If “yes”, please answer the following six questions. If “no”, you can skip to the next section.*

--Do you think you or your partner could be pregnant?  
No ☐ Yes ☐ Skip ☐

--Do you think you or your partner could have a sexually transmitted infection such as chlamydia, gonorrhea, genital warts or other?  
No ☐ Yes ☐ Skip ☐

--Have you or your partner(s) had sex without using birth control in the past year?  
No ☐ Yes ☐ Skip ☐

--Have you or your partner(s) had sex with other people in the past year?  
No ☐ Yes ☐ Skip ☐

--Have you or your partner(s) had sex without a condom in the past year?  
No ☐ Yes ☐ Skip ☐

--Have you been forced or felt pressured to have sex?  
No ☐ Yes ☐ Skip ☐

**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)?  
No ☐ Yes ☐

This includes HIV infection, organ transplant recipient, other immune system problems, or treatment with immunosuppressive medications.

**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?  

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

Do you eat fruits and vegetables every day?  

Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, soy milk, cheese, yogurt, or tofu?  

Do you limit the amount of fried food or fast food that you eat?  

Are you easily enough able to get healthy food?  

Do you often eat too much or too little food?  

Do you eat iron rich foods (such as meat, eggs, iron-fortified cereals or beans)?  

Do you eat a strict vegetarian diet?  

If you are a vegetarian, do you take an iron supplement?  

Are you happy about your weight?  

Are you trying to gain or lose weight currently?  

### Elimination:

Does you have bowel movements on a regular basis with a normal (soft) consistency?  

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 allergies to medicines:  

Please list any known food allergies:  

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

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**Signature:**  

**Date:**  

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### Clinic Use Only

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**PCP’s Signature**  

**Print Name:**  

**Date:**  

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**Patient Declined the SHA**