Medical Record Number

Patient Name

Patient Label

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	
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? ____ oz

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

Do you eat fruits and vegetables every 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 limit the amount of fried food or fast food that you eat?	Yes	No	
Are you easily able to get healthy food?	Yes	No	
Do you often eat too much or too little food?	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:

Do 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 allergies to medicines: _____

Please list any known food allergies: _____

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

_____

Signature: _____

Date: _____

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Tobacco Exposure	☐	☐	☐	☐	
☐ Physical Activity	☐	☐	☐	☐	☐ **Patient Declined the SHA**
☐ Dental Health	☐	☐	☐	☐	
PCP's Signature		Print Name:			Date: