Patient Name:

Date of Birth:

Well Child Check: 12-17 year visit questionnaire

Interval History:
Have you had any major illnesses or doctor visits since your last visit here? No☐ Yes☐

Vision/Hearing:
Do you have any concerns about how you hear or see? No☐ Yes☐

School/Activities/Employment:
What school do you attend? _____ What grade? _____
Are you or anyone else worried about your grades? No☐ Yes☐
What are your interests and future goals? _____
If you are working, where? _____
What activities do you participate in (music/arts/sports/other)?
_____
How many hours of NON-SCHOOL related screen time do you get per day? _____ hours
What do you like doing together as a family? _____

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☐
Do you use an inhaler for asthma, cough, or sports? No☐ Yes☐

Nutrition/Elimination:
What kind of milk do you drink? _____ How much per day?_____ cups
How much yogurt per day? _____ How much cheese per day? _____
What dietary restrictions do you have, if any? _____
How much juice/soda/sports/energy drinks do you drink each day? ____ oz
If you drink caffeine, what type? _____How much per day? ____ cups
Are you eating at least five servings of fruits and vegetables per day? Yes☐ No☐
Do you eat junk/fast food more than twice per week? No☐ Yes☐
Do you eat iron rich foods (meat, iron-fortified cereals, beans) daily? Yes☐ No☐
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☐
Do you have any problems with pooping or peeing? No☐ Yes☐

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

Menstrual Cycles (Periods):
Have you had your first period? Yes☐ No☐
Are your periods irregular, painful, or heavy? No☐ Yes☐
Do you have any questions about your periods? No☐ Yes☐

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Sleep:

How many hours do you sleep at night? _____ hours
Are you satisfied with your sleep? Yes☐ No☐

Staying Healthy and Safe:

Does your home have a working smoke detector? 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 when outdoors? Yes☐ No☐
Is there a gun at home? No☐ Yes☐
If you spend time with anyone who owns a gun/knife/other weapon, is the weapon safely stored? Yes☐ No☐ N/A☐
Do you wear a helmet when riding a bike, skateboard, or scooter? Yes☐ No☐
Have you ever personally witnessed abuse or violence? No☐ Yes☐
Have you been seriously hit, slapped, kicked, or physically hurt by someone (or have you hurt someone) in the past year? No☐ Yes☐
Have you ever bullied or been bullied (including cyber-bullied)? No☐ Yes☐
Do you spend time with anyone who smokes or vapes? No☐ Yes☐
If you have your driver's permit/license, have you had any tickets or accidents? No☐ Yes☐ N/A☐

Risk Assessment for Abnormal Lipid Profile (such as high cholesterol):

Have you had your cholesterol tested in the past? Yes☐ No☐
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)? _____

Please list any known food or medicine allergies:_____

Please list any medications or supplements you take:

_____

Please list any new major family medical issues: _____

Who do you live with? _____

What international travel have you had since your last well check? (where and how long)

_____

What plans do you have for international travel in the next 12 months? (where and how long)

_____

What concerns would you like to discuss today?

_____