Patient Name

Date of Birth

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 ☐

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)? 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

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 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:

Do you have bowel movements (poops) 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: _____

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

Ver.2-15-19