Patient Name

Date of Birth

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, vape, use an e-cigarette or Juul 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 ☐

Patient Name

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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 enough 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: