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Patient Label

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

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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.

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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

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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

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]

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?
___

Parent or Guardian 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:

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