

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

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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? If so, are all guns safely stored in a gun safe or locked with ammunition separate from gun?	No	Yes	Skip
Do you spend time with anyone who carries a gun, knife, or other weapon? If so, is the weapon safely stored and inaccessible?	Yes	No	N/A
Do you spend time with anyone who carries a gun, knife, or other weapon? If so, is the weapon safely stored and inaccessible?	No	Yes	Skip
Do you wear a helmet when riding a bike, skateboard or scooter?	Yes	No	
Have you ever witnessed abuse or violence?	Yes	No	
Have you been hit, slapped, kicked, or physically hurt by someone (or have you hurt someone) in the past year?	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:**

Has a family member or contact had tuberculosis or a positive tuberculin skin test (PPD)?	No	Yes	Unsure
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Were you born in a high risk country (countries *other than* the US, Canada, Australia, New Zealand or Western Europe? No    Yes

Have you traveled to (*or* had contact with people who live in a high risk country) for more than one week?  
(Countries *other than* the US, Canada, Australia, New Zealand or Western Europe) No    Yes

**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

Do either of your parents have a cholesterol of 240 or higher? No    Yes    Unsure

**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 high fat foods such as fried foods, chips, ice cream or pizza more than once 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

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 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: \_\_\_\_\_

<b><i>Clinic Use Only</i></b>	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
<input type="checkbox"/> Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<div style="border: 2px solid black; padding: 5px; display: inline-block;"> <input type="checkbox"/> <b>Patient Declined the SHA</b> </div>
<input type="checkbox"/> Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Tobacco Exposure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Physical Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Dental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PCP's Signature	Print Name:			Date:	