Stanford Children's Health

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?	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: ____________________

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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Mental Health/Sexual Health/Substance Exposure

<u>THE ANSWERS TO THESE QUESTIONS ARE CONFIDENTIAL</u>

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]

During the past 12 months, did you:

Drink any alcohol (more than a few sips)?	No	Yes	Skip
Smoke any marijuana or hashish?	No	Yes	Skip
Use anything else to get "high"?	No	Yes	Skip
("Anything else" includes illegal drugs, over-the-counter and prescription drugs, and things that you sniff or "huff".)			
Have you ever ridden in a car driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	No	Yes	Skip

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Do you smoke cigarettes or chew tobacco?	No	Yes	Skip
Do you use medicines not prescribed for you?	No	Yes	Skip
Do you have friends or family members who have a problem with drugs or alcohol?	No	Yes	Skip
Have you ever been forced or pressured to have sex?	No	Yes	Skip
Have you ever had sex (including intercourse or oral sex)?	No	Yes	Skip
If "no", you can skip the following questions:			
Do you think your partner could have a sexually transmitted infection, such as Chlamydia, Gonorrhea, Genital warts?	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 using birth control in the past year?	No	Yes	Skip
The last time you had sex, did you use birth control?	Yes	No	Skip
Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip
Did you or your partner use a condom the last time you had sex?	Yes	No	Skip
Do you have any questions about your sexual orientation (who you are attracted to) or gender identity (how you feel as a boy, girl, or other gender)?	No	Yes	Skip

<u>End of confidential section</u>