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## WELL ADOLESCENT CHECK UP: 12 – 17 Years

Patient's Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

### **Interval History:**

Have you been ill since the last check-up?  Yes  No If yes, describe: (Hospitalization, surgery, ongoing illness) \_\_\_\_\_

What medications, supplements, or vitamins are you taking, if any? \_\_\_\_\_

Do you have any allergies?  Yes  No What kind? \_\_\_\_\_

What concerns or questions do you have, if any? \_\_\_\_\_

### **Family Medical History:**

Does either of your parents have a history of high cholesterol?  Yes  No

Does anyone in your family have diabetes?  Yes  No High blood pressure?  Yes  No

Have your parents or grandparents had heart disease or a stroke before they were 55 yrs old?  Yes  No

### **Nutrition:**

How is your appetite?  Good  Average  Poor How many times a day do you brush your teeth? \_\_\_\_\_

Milk:  Whole milk  2% or 1%  Skim  Soy How many cups a day? \_\_\_\_\_

How many meals per day? \_\_\_\_\_ Servings of meat per day? \_\_\_\_\_

Servings of vegetables per day? \_\_\_\_\_ Cups / Cans of soda per day? \_\_\_\_\_

Cups of juice per day? \_\_\_\_\_ Are you happy with your current weight?  Yes  No

Do you play sports? If so, what sports? \_\_\_\_\_

Do you need a sports physical today?  Yes  No

What other exercise or physical activity do you do on a regular basis? \_\_\_\_\_

### **School:**

What grade are you in? \_\_\_\_\_ What school do you attend? \_\_\_\_\_

Have you ever repeated a grade?  Yes  No If yes, which grade & why? \_\_\_\_\_

What kind of grades do you make? (circle) A, B, C, D, F

What concerns, if any, do you have about your learning abilities or school performance? \_\_\_\_\_

### **TB Screening Questions:**

Have you been around anyone ... who has HIV or uses IV drugs?  Yes  No

... who lives in a group or nursing home?  Yes  No ... who has traveled to another country?  Yes  No

... who has been homeless or incarcerated (in jail)?  Yes  No

### **Safety / Home:**

Do you drive a car?  Yes  No Do you use a seat belt?  Yes  No Any car accidents?  Yes  No

Do you wear a helmet when riding a bike or motorcycle?  Yes  No

Do you have a working smoke detector?  Yes  No

Are you exposed to tobacco smoke?  Yes  No Is there a gun in your home?  Yes  No

Who lives in your household? \_\_\_\_\_

Any pets? If yes, what kind? \_\_\_\_\_

→ Please indicate relationship of person completing form (self, mother, father, grandparent, etc.):

Signature: \_\_\_\_\_

Date: \_\_\_\_\_