Stanford Children's Health

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

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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 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:

Has a family member or contact had tuberculosis or a positive tuberculin skin test (PPD)?	No	Yes	Unsure
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

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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

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

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	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	☐ **Patient Declined the SHA**
PCP's Signature		Print Name:			Date:

Ver5-7-15