Adolescent – Well Care Form **Patient Name:_____D.O.B_____**

Please fill in the blank or check the appropriate answer as it pertains to your child.

Household

Who lives in the home (Father, mother, brother, sister, etc.)? _____

Development

Doing well in school _____	▢ Yes	▢No
Interacts well with others _____	▢ Yes	▢No
Maintains friendships _____	▢ Yes	▢No
Acceptable behavior at home and in school _____	▢ Yes	▢No
Engages in one hour of exercise daily_____	▢ Yes	▢No
Recreational screen time less than 2 hours per day _____	▢ Yes	▢No

Please list after school activities including work and sports _____

_____

_____

Nutrition

Are you consuming a low fat or nonfat milk product _____	▢ Yes	▢No
Eating three meals per day with snacks and have a relatively well balanced diet?____	▢ Yes	▢No
Avoiding excess added sugars (juice, candy, sweets) and animal fats?_____	▢ Yes	▢No
Consuming green vegetables?_____	▢ Yes	▢No

Bowel habits

Every day or every other day bowel movement?_____	▢ Yes	▢No
Bowel movements are painless and non-bloody? _____	▢ Yes	▢No

Safety

Do you wear a seat-belt in the automobile?_____	▢ Yes	▢No
Do you wear a helmet with cycling/boarding/skating?_____	▢ Yes	▢No
Are you exposed to tobacco smoke?_____	▢ Yes	▢No
Are there any improperly stored firearms in your home?_____	▢ Yes	▢No
Is the hot water temperature set low enough to prevent accidental burns?_____	▢ Yes	▢No
Are there working smoke detectors in your home?_____	▢ Yes	▢No

If you would like to share any questions, concerns, or information, please use the space below.

_____

_____

_____

_____

_____

Please complete both sides of this form

Please circle any of the questions below to which your answer is "YES".

Tuberculosis Risk Assessment:

- Your child was born in, traveled to or lived in a "tuberculosis high-risk" country?
- Your child has a family member or has had contact with anyone with either active tuberculosis or a history of tuberculosis disease?
- Your child has a family member with a positive tuberculin skin test?

Social Determinants of Health Assessment:

- Within the past 12 months, have you had worries that food would run out before your family got enough money to buy more?
- Within the past 12 months, were there times that food ran out and your family didn't have enough money to get more?
- Have you needed help reading instructions, pamphlets, or other written material from a doctor or pharmacy?
- In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?
- In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

Heart Disease/Cholesterol Risk Assessment:

- Is there a family history of parents/grandparents under 55 years of age with a heart attack, heart surgery, angina or sudden cardiac death?
- Has the child's mother or father been diagnosed with high cholesterol? (240 mg/dL or higher)
- Is the child/adolescent overweight?
- Does the patient have a history of smoking?
- Does the patient have a history of Lack of physical activity?
- Does the patient have a history of High blood pressure?
- Does the patient have a history High cholesterol?
- Does the patient have a history Diabetes Mellitus?

Below this line is for Office Use:

Weight _____

Height _____

Blood Pressure _____

Vision Test: Left 20/ ___ Right 20/___

Hearing Test: Passed Failed

Please complete both sides of this form