16-21 YEAR OLD

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Patient Name: ____

Person Filling Out Form: ____

Relationship to Patient: ____

CONCERNS

yes	no	Do you have any special concerns today?

PERSONAL MEDICAL HISTORY

yes	no	Does your child take any medications (daily or as needed)? If so, please list: ________________
yes	no	Have you ever had any reactions to medications?
yes	no	Do you take any vitamins, supplements, "alternative medicines", or therapies?
yes	no	Do you have any ongoing major medical illnesses (like asthma, diabetes, etc.)? What? __________
yes	no	Have you ever had surgery or had to spend the night at the hospital?
yes	no	Are there any major changes or stresses in the family (moves, deaths, separation, etc.)?
yes	no	Has a parent or household member ever had a problem with alcohol or drug use?
yes	no	Is there any new information to add to family medical history since the last well child visit?

FAMILY HISTORY

yes	no	unknown	Are there any major illnesses in the family? Which ones? ________________
yes	no	unknown	Is there any family history of sudden cardiac death or arrhythmias?
yes	no	unknown	Does either biologic parent have elevated cholesterol or been prescribed a cholesterol medication?
yes	no	unknown	Has any family member died of heart problems or of sudden death **BEFORE AGE 50**?
yes	no	unknown	Has anyone in your family died for no apparent reason?
yes	no	unknown	Does anyone in your family have Marfan syndrome, sickle cell anemia/trait?

NUTRITION

yes	no	Do you have at least 4-5 servings of fruits/vegetables each day?
yes	no	Do you have at least 2-3 servings of calcium each day? (milk, cheese, yogurt or supplements)?
yes	no	Do you eat food rich in iron daily? (Meat, green leafy vegetables, iron supplements)?
yes	no	Do you drink anything other than milk and water? If so, what? ________________
yes	no	Do you drink any caffeinated beverages, energy drinks, or protein drinks?
________		How many times per week do you eat fast food?
________		How many times per week does your family eat meals together?

PREVENTIVE HEALTH

yes	no	Have you seen a dentist in the past 6 months?
yes	no	Do you brush your teeth twice daily?
yes	no	Do you always wear a seat belt?
yes	no	Do you use a cell phone or use headphones while driving?
yes	no	Do you get 8-10 hours of sleep each night?
yes	no	Do you watch more than 2 hours of recreational screen time per day (TV, tablet, phone, movies, video games, etc.)?
yes	no	Do you have a TV, phone, tablet, or computer in your bedroom?
yes	no	Do you have outdoor time daily?
yes	no	Do you always use a helmet when using a bike, a scooter, a skateboard, skiing, etc.?
yes	no	Do you or anyone you live with smoke or vape tobacco or marijuana?
yes	no	Are there smoke alarms, fire extinguishers, and carbon monoxide alarms in your home?
yes	no	Have those alarms been checked in the past 12 months?
yes	no	Has a family member or close contact had tuberculosis or had a positive test for tuberculosis?
yes	no	Were you born in or traveled to a country for more than a week that may have a higher risk of tuberculosis and had contact with the resident population (countries outside the United States, Canada, Australia, New Zealand, or Western European countries)?

Please continue on the other side.

On average, how difficult was it for your family to meet expenses for basic needs like food, housing, and/or utilities in the past year? (Please circle one that most applies):

Never Seldom Some of the time Most of the time

REVIEW OF SYSTEMS *(IN THE PAST **TWO WEEKS**, HAVE YOU HAD ANY PROBLEMS WITH THE FOLLOWING THAT YOU WOULD LIKE TO DISCUSS **TODAY**?)*

yes no Headaches, fainting, dizziness, any loss of consciousness
yes no Eyes, vision, ear pain, hearing, nosebleeds, or snoring that disrupts your sleep
yes no Coughing, breathing, shortness of breath, wheezing, limited endurance, or chest pain
yes no Breast lump, discharge or pain
yes no Frequent stomachaches, vomiting, diarrhea, constipation, or blood in the stools
yes no Urination (change in frequency, or blood in the urine)
yes no Neck, back, or extremities (feet, legs, arms, hands)
yes no Problems with skin (moles or birthmarks that are changing, sores

FEMALES:

________ When was your first menstrual cycle (years old)?
________ When was the first day of your most recent period?
yes no Menstrual irregularities, pain, or other concerns about your period?

ACADEMIC

What school do you attend? ______________________________ What grade level? __________
yes no Are you scoring on or above grade level?
yes no Do you enjoy reading?
yes no Are you involved in extracurricular activities? Which ones? ________________
yes no Do you receive any extra services? Please circle: tutoring, PT, OT, speech therapy, etc.
yes no Do you have a 504 plan or IEP?
yes no Do you or the school have any concerns about your academics or behavior?

VISION/ HEARING

If you have had a hearing or vision screen in the past 12 months, please indicate below:

Recent Hearing Screen Date _______________ Recent Vision Screen Date _______________

PHYSICAL ACTIVITY QUESTIONS

yes no Do you consider yourself physically active?
yes no Has a health care provider ever denied or restricted your participation in sports for any reason?
yes no Have you ever passed out or nearly passed out **WHILE** you are actually running or exercising?
yes no Have you ever passed out or nearly passed out **AFTER** you stopped running or exercising?
yes no Do you get discomfort, pain, or pressure in your chest during exercise?
yes no Does your heart skip beats or beat irregularly during exercise?
yes no Has a health care provider ever told you that you have: high blood pressure, heart murmur, heart infection, or Kawasaki's disease?
yes no Has a health care provider ever ordered a test for your heart (like an ECG or echocardiogram)?
yes no Do you have asthma, or has a doctor ever prescribed an inhaler to you?
yes no Do you get tired or short of breath more quickly than your friends during exercise?
yes no Have you experienced a muscle or bone injury that does not feel fully healed?
yes no Were you born without or are you missing a kidney, an eye, a testicle, spleen, or any other organ?
yes no Have you had infectious mononucleosis (mono) **WITHIN THE LAST MONTH**?
yes no Have you had a herpes or MRSA **skin** infection?
yes no Have you ever had a head injury or concussion? If so, when? ____________
yes no Have you ever had a seizure?

If you answered YES to any of the above physical activity questions, please explain:

____

____

____

Thank you for filling out this form.

PATIENT HEALTH QUESTIONNAIRE
PHQ-9 – Nine Symptom Checklist

www.pedsnw.net

Patient Name: ______________________________

Person Filling Out Form: ______________________________

Relationship to Patient: ______________________________

Date: ________________

1. Over the *last 2 weeks*, how often have you been bothered by any of the following problems?

		Not at all 0	Several days 1	More than half the days 2	Nearly everyday 3
a.	Little interest or pleasure in doing things	❑	❑	❑	❑
b.	Feeling down, depressed, or hopeless	❑	❑	❑	❑
c.	Trouble falling or staying asleep, or sleeping too much	❑	❑	❑	❑
d.	Feeling tired or having little energy	❑	❑	❑	❑
e.	Poor appetite or overeating	❑	❑	❑	❑
f.	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	❑	❑	❑	❑
g.	Trouble concentrating on things like school work, reading,or watching TV	❑	❑	❑	❑
h.	Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	❑	❑	❑	❑
i.	Thoughts that you would be better off dead or of hurting yourself in some way	❑	❑	❑	❑

2. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
❑	❑	❑	❑

Total # Symptoms: ____________________ **Total Score:** ____________________