Patient Name:

Date of Birth:

Well Adult Check: 18-21 year visit questionnaire

Interval History:
Have you had any major illnesses or doctor visits since last seen here? No ☐ Yes ☐

Vision/Hearing:
Do you have any concerns about how you hear or see? No ☐ Yes ☐

School/Activities/Employment:
What school do you attend? _____ What year? _____
Are you worried about your grades? No ☐ Yes ☐
What are your interests and future goals? _____
If you are working, where? _____
What activities do you participate in (music/arts/sports/other)?
_____
How many hours of NON-SCHOOL related screen time do you get per day? _____ hours

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 ☐
Do you use an inhaler for asthma, cough, or sports? No ☐ Yes ☐

Nutrition/Elimination:
What kind of milk do you drink? _____ How much per day? _____ cups
How much yogurt per day? _____ How much cheese per day? _____
What dietary restrictions do you have, if any? _____
How much juice/soda/sports/energy drinks do you drink each day? _____ oz
Do you eat at least 5 servings of fruits and vegetables every day? Yes ☐ No ☐
Do you limit the amount of junk/fast food that you eat? Yes ☐ No ☐
Do you often eat too much or too little food? No ☐ Yes ☐
Do you eat iron rich foods (meat, iron-fortified cereal, beans) daily? Yes ☐ No ☐
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 ☐
Do you have any problems with urinating or having a bowel movement? No ☐ Yes ☐

For Women Only:
Are your periods irregular, painful, or heavy? No ☐ Yes ☐
Do you have any questions about your periods? No ☐ Yes ☐

Sleep:
How many hours do you sleep at night? _____ hours
Are you satisfied with your sleep? Yes ☐ No ☐

Lipid Screening: Have you every had your cholesterol tested in the past? Yes ☐ No ☐

Patient Name:

Date of Birth:

Staying Healthy and Safe:

Does your home have a working smoke detector?	Yes☐	No☐	
Do you always wear a seat belt when in the car?	Yes☐	No☐	
If you drive, have you ever had any tickets or car accidents?	No☐	Yes☐	N/A☐
Do you use your phone while driving?	No☐	Yes☐	N/A☐
Do you swim?	Yes☐	No☐	
Do you use sun protection when you are outdoors?	Yes☐	No☐	
Is there a gun in your home?	No☐	Yes☐	
Have you been hit/slapped/kicked/physically hurt by someone this 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 or vape where you live?	No☐	Yes☐	
Do you smoke cigarettes, chew tobacco, or vape?	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/medicines to help you sleep/relax/feel better/lose weight?	No☐	Yes☐	Skip☐
Do you drink alcohol?	No☐	Yes☐	Skip☐

If "yes", please answer the following three questions. If "no", you can skip to the next section.

--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☐
Have you ridden in a car with someone who has been drinking/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/your partner could be pregnant?	No☐	Yes☐	Skip☐
--Do you think you/your partner could have a sexually transmitted infection like chlamydia, gonorrhea, genital warts or other?	No☐	Yes☐	Skip☐
--In the past year:			
Have you/your partner(s) had sex without using birth control?	No☐	Yes☐	Skip☐
Have you or your partner(s) had sex with other people?	No☐	Yes☐	Skip☐
Have you/your partner(s) had sex without a condom/?	No☐	Yes☐	Skip☐
--Have you been forced or felt pressured to have sex?	No☐	Yes☐	Skip☐

Please list any medications or supplements you take:

_____

Please list any new major family medical issues: _____

Who do you live with? _____

What international travel have you had since your last well check? (where and how long)

_____

What international travel plans do you have for the next 12 months? (where and how long)

_____

What concerns do you have today?

_____