Physicians at Sugar Creek
An Affiliate of MEMORIAL HERMANN

14023 Southwest Freeway
Sugar Land, TX 77479
218.325.4100

14-16 Year Well Child Exam Form – FEMALE

HEALTH HISTORY

Do you have any questions or concerns about your health that you would like to discuss today?

____

____

____

What is your health Status? **Good Fair Poor**

Have you been to the emergency room in the past 12 months: **Yes No**

If yes, list why: ____

Have you been treated in the hospital in the past 12 months? **Yes No**

If yes, list why: ____

Have you ever had any reactions to vaccines / immunizations: **Yes No**

Have you seen a dentist in the last 6 months: **Yes No**

How many times a day do you brush their teeth? ___ How many times a day do you floss? ___

HOME and FAMILY

Who do you live with: ___________ How many brothers and sisters do you have? ______

What do you live in? ___________ How many bedrooms are in your home? _____

Do you share a bedroom: **Yes No** Does anyone in the home smoke? **Yes No**

Is your Father Involved in your life? **Yes No**

How is your relationship with your brothers and/or sisters? **Good Fair Poor N/A, only child**

Is there any history of abuse: **Yes No** Is there any history of neglect? **Yes No**

Does anyone in home use drugs: **Yes No** Is there a history of domestic violence? **Yes No**

Has CPS ever been to your home? **Yes No** If yes, is your CPS case still open? **Yes No**

Has your child ever been in foster care? **Yes No** If yes, how many times? _____

Are you feeling stressed? **Yes No**

Do you have pets in the home: **Yes No** If yes, what type? _________

Do you have pets in the home: **Yes No** If yes, what type? _________

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SUBSTANCE USE

Circle what describes you:

- **My parents / guardian smoke in the home**
- **My friends smoke**
- **No one I am around smokes**

Have you ever smoked? **Yes No**

If yes, what best describes you: **I've tried it before** **I use to but I quit** **I smoke on occasion** **I smoke frequently** **I smoke daily** How many packs a day? ________

Circle what describes you:

- **My parents / guardian and my friends do not drink alcohol**
- **My parents / guardian drink alcohol on occasion**
- **My parents / guardian drink alcohol regularly**
- **My parents / guardian often get drunk**
- **My friends drink alcohol**

Do you drink alcohol? **Yes No** If yes, what do you drink? _________________ How often? _____________

Circle what describes you:

- **No one I am around smokes marijuana**
- **My parents / guardian smoke marijuana**
- **My friends smoke marijuana**
- **I know other people that smoke marijuana**

Have you ever smoked marijuana? **Yes No**

If yes, what best describes you: **I've tried it before** **I smoke it on occasion when my friends have it** **I smoke it on occasion when I can buy it** **I smoke it regularly** **I smoke it daily** **I sell it**

Have you ever used other drugs? **Yes No**

If yes, what best describes you: **I've tried it before** **I use on occasion when my friends have it** **I use on occasion when I can buy it** **I use regularly** **I use daily** **I sell it**

What drug do you use? ___________________________

SEXUALITY

Have you ever had sex? **Yes No**

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FEMALE HEALTH HISTORY

What was the date of your last period: ___________ ☐ ***Check if you have never had a period and skip down to General Health section.***

How old were you when you first got your period: ___ Are your periods **regular** or **irregular** (circle one)

How many days are there between your periods? _____ How many days do your periods last? ____

How many pads/tampons do you use a day when you are on your period? ______

Do you have any menstrual problems? **Yes** **No** What kind? _______________

What do you use? **Tampons** **Pads** **Both** Do you use douche? **Yes** **No**

Have you ever been pregnant? **Yes** **No** If yes, how many times? _____

Did you give birth? **Yes** **No**

If no, what happened: ________________________ **If yes**, how many?_________

GENERAL HEALTH

Do you eat from all four food groups including fruit and vegetables? **Yes** **No**

What type of milk do you drink? **Whole** **2%** **1%** **Fat free** **Lactose free** **Soy**

What else do you drink and how many glasses a day do you drink**?** **___ Glasses of juice** **___ Glasses of water** **___ glasses of soda** **___ glasses of tea** **___ cups of coffee** **___ cans of energy drinks**

Do you have any problems using the bathroom? (bowel movements or urinating) **Yes** **No**

How many hours a night do you sleep? _____

Do you exercise: **Yes** **No** What kind? ____________

Do you play sports? **Yes** **No** What kind?_______________

What clubs/activities are you in at school or after school? ____________

How many hours a day do you: Watch TV?_______ Use the computer? _____ Play video games? ______

Would you say you have many friends or few? _____

Would you say you have high self-esteem or low? _______

SCHOOL

How are your grades? Excellent good fair poor

Are your teachers concerned with your school grades? **Yes** **No** If yes, which classes? _________________

What are your future career goals? __________________________________

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HEARING

Do you have a problem hearing over the telephone? **Yes No**

Do you have trouble following the conversation when 2 or more people are talking at the same time? **Yes No**

Do you have trouble heading with a noisy background? **Yes No**

Do you find yourself asking people to repeat themselves? **Yes No**

Do you misunderstand what others are saying and respond inappropriately? **Yes No**

VISION

Do you complain that the blackboard is hard to see? **Yes No**

Have you ever failed a school vision screening test? **Yes No**

Do you hold books close to your eyes to read? **Yes No**

Do you have trouble recognizing faces at a distance? **Yes No**

Do you tend to squint? **Yes No**

GENERAL SAFETY

Do you wear a seat belt when riding in a car or truck? **Yes No**

Do you have these things in your home:

- Smoke detector **Yes No**
- Carbon monoxide detector **Yes No**
- Fire extinguisher **Yes No**

FAMILY HISTORY:

Is there any history in your family of:

- Heart disease **Yes No**
- High Cholesterol **Yes No**
- Overweight or Obesity **Yes No**

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TUBERCULOSIS RISK ASSESSMENT:

1. Have you been tested for TB? **Yes NO Do Not Know**
   If yes, when? ____________
2. Have you ever had a positive tuberculin skin test (TST)? **Yes NO Do Not Know**
   If yes, when? _______________
3. TB can cause fever that can last days or weeks. It can cause weight loss, a bad cough (lasting over two weeks), or coughing up blood.
   a. Have you been around anyone with any of these problems? **Yes NO Do Not Know**
   b. Have you been around anyone sick with TB? **Yes NO Do Not Know**
   c. Have you ever had any of these problems or do they have them now? **Yes NO Do Not Know**
4. Were you born in another part of the world like Mexico or Latin America, the Caribbean, Africa, Eastern Europe, or Asia? **Yes NO Do Not Know**
5. Have you been to Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe, or Asia for more than 3 weeks? **Yes NO Do Not Know**
   Which country or countries did you visit?_________________________
6. Have you spent more than 3 weeks with anyone who:

   Uses needles for drug use? Has AIDS? **Yes NO Do Not Know**
   Was or is in jail or prison? **Yes NO Do Not Know**
   Has just come to the United States from another country? **Yes NO Do Not Know**

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Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	
TOTAL:				

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

10. 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 ______

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