

17-21 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**

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? _____

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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? _____

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 hearing 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**

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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**

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? _____

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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**

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 fidgety 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 + +

(Healthcare professional: For interpretation of TOTAL, 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	_____