Pediatric Health Maintenance: 13-21 Years

Well Visit CONFIDENTIAL Questionnaire

To be completed by patient only. Please complete BOTH sides

What would you like to talk about with your physician or nurse practitioner today?

If you are under the age of 18 and your Provider determines that the care you need requires the consent of an adult (i.e., vaccine), is there an adult with you today?

YES	NO	If NO, please enter name, relation, and telephone of an adult the care team can contact if consent is needed					
☐	☐	Name		Relationship		Telephone	

About You

First and Last Name			Date of birth
Who do you live with?			
Where do you attend school?	Grade:	GPA:	Number school days missed this year:
What sports/activities (music, clubs, work, etc.) do you participate in?			
Which gender pronouns(s) do you prefer?			

I identify as: ☐ male ☐ female ☐ trans ☐ other:

I am interested in/attracted to: ☐ boys ☐ girls ☐ both ☐ neither ☐ unsure

General Health

YES	NO	**Please answer the following questions.**
☐	☐	Do you exercise at least three times a week?
☐	☐	Do you sleep at least 8-10 hours at night?
☐	☐	Are you happy with your current weight?
☐	☐	Do you eat healthy foods most of the time?
☐	☐	Do you ever go on a diet, restrict your eating, or eat in binges?
☐	☐	Are you taking any medication(s)? Please list them:
☐	☐	Do you take any supplements such as vitamin D, calcium or iron?

Behavioral Health

YES	NO	During the **past 12 months**, did you do any of the following:
☐	☐	Drink alcohol (more than a few sips)?
☐	☐	Use any marijuana or other drugs?
☐	☐	Use nicotine (vape, Juul, cigarettes, etc.)?
☐	☐	Are you seeing a counselor, mental health therapist, or psychiatrist?
☐	☐	Do you have questions about dating, sex birth control, sexually transmitted diseases or pregnancy?

Who do you share your concerns with?

What are you most proud of?

Do you feel overly stressed or unsupported?

Over the last 2 weeks, how often have you been bothered by the following problems:	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. Feeling nervous, anxious, or on edge	○ 0	○ 1	○ 2	○ 3
4. Not being able to stop or control worrying	○ 0	○ 1	○ 2	○ 3
5. Thoughts that you would be better off dead, or of hurting yourself in some way	○ 0	○ 1	○ 2	○ 3

PATIENT NAME & ID #

Please continue to next page

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Respiratory ☐ **None of the symptoms below**
☐ Asthma
☐ Trouble breathing, chest tightness, coughing with exercise
Cardiovascular ☐ **None of the symptoms below**
☐ Heart tests (ECG, Echo, etc.) done in the past
☐ Chest pain when you exercise
☐ Passed out or nearly passed out during exercise
☐ Racing heart or skipped beats
☐ Close relative with heart problem or sudden death before age 50
Neurologic ☐ **None of the symptoms below**
☐ Severe or frequent headaches
☐ Convulsions/Seizures
☐ Head injury/concussion When?
☐ Loss of consciousness (passed out)
Other ☐ **None of the symptoms below**
☐ Vision or hearing concerns
☐ Acne or other skin concerns
☐ Stomach or other digestive concerns
☐ Urinary or genital concerns
☐ Pain or injury that concerns you? If so where?
CONTACT INFORMATION
If you have your own personal/mobile phone that only you answer, please provide the number in case we need to reach you in follow-up of a personal matter (for example, confidential test results).
Phone number (with area code)

YES	NO	Please answer the following question.
☐	☐	Do you have a voice identifier on your voice mail?
☐	☐	Is it OK to leave a detailed voice message (example: test results)
		If you check NO, we will only leave a message asking you to call back.

FEMALES AT BIRTH
When did your periods first start?_______________; or My periods haven't started yet.

YES	NO	If your periods have started, please answer the following questions.
☐	☐	Do you have cramps, heavy or irregular periods?
☐	☐	Are you using hormonal contraceptives (birth control pills, patch, "Depo" shots, NuvaRing, IUD, Nexplanon)?
☐	☐	Have you ever been pregnant?
What is the longest amount of time you've gone *between* periods?		

By typing my name in the box below, I understand that I am providing a binding electronic signature to the Well Visit 13-21 Years Confidential form.

Completed by (name and relationship to patient) | Date (month/date/year)

PATIENT NAME & ID #

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