OBERLIN ROAD PEDIATRICS

PATIENT

Well Child Check: School Aged Child (15-17 years)

Your Name: _____

Do you have any concerns, questions, or problems that you would like to discuss today? If yes, please describe:

_____

_____

What things do you like to do? What would you like us to know about you? What things do you excel at?

_____

_____

_____

Current grade/name of school _____

Nutrition:

Do you get 4 servings of dairy a day?	□ Yes	□ No	
What milk do you drink? _____			
Does your diet include iron-rich foods daily (meat, beans, enriched cereals/cheerios)?	□ Yes	□ No	
Do you eat a vegetarian diet (do not eat red meat, chicken, fish, or seafood)?	□ No	□ Yes	
If you are a vegetarian, do you take an iron supplement?	□ Yes	□ No	□ N/A

Females:

Do you think you have excessive menstrual bleeding?	□ No	□ Yes

Dental Health:

Do you brush your teeth 2x per day?	□ Yes	□ No

CARDIOVASCULAR SCREEN:

Have you ever fainted while exercising?	No	Yes
Do you typically cough or have shortness of breath when exercising? Outside of deconditioning?	No	Yes
Have you gotten aching chest pain when you exercise?	No	Yes
Has anyone in your family had a heart attack or stroke before age 55?	No	Yes
Did anyone in the family die suddenly while exercising?	No	Yes

MENTAL HEALTH SCREEN (PHQ-2)

In the past two weeks, how often have you been bothered by the following symptoms:

1. Feeling down, depressed, irritable, or hopeless?
   Not at all Several Days More than half of the time Nearly every day

2. Little interest or pleasure in doing things?
   Not at all Several Days More than half of the time Nearly every day

Sexual and Gender Health

If you have been in romantic relationships, have you always felt safe and respected?	□ Yes	□ No
Have you ever had sex, including oral, vaginal, or anal sex? *(if no, skip to the *question*)*	□ No	□ Yes
Have you had multiple partners in the past year?	□ No	□ Yes
Do you and your partner use condoms every time?	□ Yes	□ No
Do you and your partner always use another form of birth control along with a condom?	□ Yes	□ No
Are you aware of emergency contraception?	□ Yes	□ No
Do you sleep with… men women both?		
Have you ever been treated for an STD?	□ No	□ Yes
*Do you have questions about gender identity?	□ No	□ Yes

Do you identify as… male female _____

Social Health

Have you ever smoked cigarettes or used e-cigarettes?	□ No	□ Yes
Have you ever drunk alcohol?	□ No	□ Yes
Have you ever used drugs, including marijuana or street drugs?	□ No	□ Yes
Have you ever prescription drugs that were not given to you for a medical condition?	□ No	□ Yes
Is there anyone in your life whose alcohol, tobacco, or drug use concerns you?	□ No	□ Yes

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Who lives with you at home? _____

Are parents: single married divorced separated

Females: Do you have concerns about your period?	□ No	□ Yes
Do you get along with your family?	□ Yes	□ No
Does your family do things together?	□ Yes	□ No
Do you follow rules and limits?	□ Yes	□ No
Do you get along with your friends and others at school?	□ Yes	□ No
Are you doing well in school?	□ Yes	□ No
Do you have plans for what you will do after high school?	□ Yes	□ No
Do you have any concerns about your weight?	□ No	□ Yes
Are you currently doing anything to try to gain or lose weight?	□ No	□ Yes
Do you eat fruits and vegetables?	□ Yes	□ No
Do you drink sugar sweetened beverages (juice, soda, sports drinks)?	□ No	□ Yes
Do you ever skip meals?	□ No	□ Yes
Do you eat meals together with your family?	□ Yes	□ No
Are you physically active at least 1 hour every day? This includes running, playing sports, or doing physically active things with friends?	□ Yes	□ No
How much time every day do you spend watching TV, playing video games, or using computers, tablets, or smartphones (not counting schoolwork)?	_____	
Do you get 8 or more hours of sleep each night?	□ Yes	□ No
Do you have trouble sleeping at night or waking up in the morning?	□ No	□ Yes
Do you harm yourself, such as by cutting, hitting, or pinching yourself?	□ No	□ Yes
Do you use earplugs or sound-canceling headphones to protect your hearing around loud noises or at concerts?	□ Yes	□ No
Do you always wear a lap and shoulder seat belt?	□ Yes	□ No
Do you always wear a helmet to protect your head when you are biking, skateboarding, or skating?	□ Yes	□ No

Do you always wear a life jacket when you do water sports?	□ Yes	□ No
If you have started driving, do you follow the safety rules for young drivers?	□ Yes	□ No
Do you have someone you can call for a ride if you feel unsafe driving yourself or riding with someone else?	□ Yes	□ No
Do you use sunscreen?	□ Yes	□ No
Do you visit tanning parlors?	□ No	□ Yes
Do you feel safe at home?	□ Yes	□ No
Do you feel safe at school and getting to and from school?	□ Yes	□ No
Have you been bullied in person, on the internet, or through social media?	□ No	□ Yes
Have you ever been forced or pressured to do something sexual you didn't want to do?	□ No	□ Yes
Have you ever been in a relationship with someone who threatened or hurt you?	□ No	□ Yes
In the past 12 months, have you had trouble having enough food to eat or have concerns that you might not have enough?	□ No	□ Yes