OBERLIN ROAD PEDIATRICS

Well Adult Check: (18+ years)

Your Name: _____

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

_____

_____

What are you most proud of about yourself?

_____

_____

What year are you in school and where? _____

Do you take any medications or supplements, including vitamins?	□ No	□ Yes: _____
Do you have known allergies to foods/medicines?	□ No	□ Yes: _____
Do you see any specialists outside of Oberlin?	□ No	□ Yes: _____

Dental:

Do you brush your teeth 2x a day?	□ Yes	□ No
Do you floss your teeth once a day?	□ Yes	□ No
Do you see the dentist regularly?	□ Yes	□ No

Tuberculosis screen:

Have you had close contact with a person who has tuberculosis disease or who has had a positive tuberculosis test?	□ No	□ Yes
Were you or any household member born in or traveled to a high-risk country? (This includes countries in Africa, Asia, Latin America, and Eastern Europe)?	□ No	□Yes

Social Health:

Do you smoke cigarettes or use e-cigarettes?	□ No	□ Yes
Do you chew tobacco or use other tobacco products?	□ No	□ Yes
Do you drink 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

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 _____

Nutrition:
Do you get 3 servings of dairy a day? □ Yes □ No
What milk do you drink? _____
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
Females:
Do you have excessive menstrual bleeding □ No □ Yes
Do you have problems with cramping, irregularity, etc.? □ No □ Yes

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Where do you live most of the time? _____
Are parents: single married divorced separated

Do you get along with the people you live with? □ Yes □ No
Do you have ways that help you deal with feeling angry? □ Yes □ No

Are you physically active most days? □ Yes □ No
This includes running, playing sports, or doing physically active things with friends?
How much time do you spend on screen time unrelated to work or school each day? _____
Do you have trouble getting sleep 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 often listen to loud music? □ No □ Yes

Do you always wear a lap and shoulder seat belt? □ Yes □ No
Do you always wear a helmet to protect your head when you ride a bike, a skateboard, a motorcycle, or an ATV? □ Yes □ No
Do you ever use your phone or tablet while driving, even at stop signs? □ No □ Yes
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 have a close friend? □ Yes □ No
Do you get along with members of your family? □ Yes □ No

Do you have activities you like to do after school or work or on the weekends? □ Yes □ No
Do you help others out at home, at school, or in your community? □ Yes □ No

Do you feel really stressed out all the time? □ No □ Yes
Do you have strategies to reduce or relieve your stress? □ 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 fruit and vegetables every day?	□ 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
Do you use sunscreen?	□ Yes	□ No
Do you visit tanning parlors?	□ No	□ Yes
Do you have access to unlocked guns?	□ No	□ Yes
Have you ever been hit, or physically hurt while on a date?	□ No	□ Yes
Have you ever been touched in a sexual way against your wishes or without your consent?	□ No	□ Yes
Have you ever been forced to have sexual intercourse?	□ No	□ Yes
Have you ever been in a relationship with someone who threatened or hurt you?	□ No	□ Yes
Do you feel threatened by anyone?	□ No	□ Yes
Are you worried that you might hurt someone else?	□ No	□ Yes
Do you feel safe in your current living situation?	□ Yes	□ No
In the past 12 months, did you worry that your food would run out before you got money to buy more?	□ No	□ Yes
In the past 12 months, did the food you bought not last, and you did not have money to buy more?	□ No	□ Yes