18-21 Year Visit Questionnaire

Patient's Last Name: _____ **First Name:** _____ **Birthdate:**_____ **Today's Date:**_____

General:	CIRCLE	(If yes, explain below)
Do you have any specific concerns for today's visit?	No	Yes
Are you taking any prescription medications?	No	Yes
Are vaccines covered by your insurance plan?	No	Yes
Are you seeing a specialist for any ongoing medical problem(s)?	No	Yes
Have you been seen in a hospital ER or treatment center since the last visit here?	No	Yes
Do you have any ongoing medical problems or diagnosis? (If yes, please list on bottom.)	No	Yes
Family Medical:		
Do the parents have any significant medical issues that we should be aware of?	No	Yes
Have there been any other significant family medical issues recently?	No	Yes
Social:		
Are the biological parents married?	No	Yes
Are there any new stressful events, losses, deaths, job changes, or social issues of concern recently?	No	Yes
Are there any smokers in the household? (If yes, please indicate who)	No	Yes
Symptom Review:		
Have you had any fever (over 100.4), runny nose or significant cough in the last 3 days?	No	Yes
Do you have any concerns regarding your sleep habits?	No	Yes
Are there any psychological issues that are a concern to you or a concern to your parents?	No	Yes
Do you wear glasses or contacts? If yes, Please circle: Glasses Contacts	No	Yes
Do you have any concerns regarding your hearing?	No	Yes
Do you have any significant concerns regarding your breathing?	No	Yes
Have you had any episodes of vomiting recently?	No	Yes
Have you had recent episodes of abdominal pain that is frequently recurring or persistent ?	No	Yes
Do you have any concerns regarding your bowel habits?	No	Yes
Do you have any concerns regarding your voiding/urinary habits?	No	Yes
Have you have recent joint, bone or muscle pain that is frequently recurring or persistent ?	No	Yes
Have you had recent headaches that are frequently recurring or persistent ?	No	Yes
Do you have any unusual rashes that you are concerned about?	No	Yes

Explain 'YES" Answers: _____

Consent for Sharing Medical Information with Parent(s): Do you agree to allow the providers to share medical information, induding lab test results, with your parent(s): No Yes Signature of Patient:

_____

(Version 7-5-20)

Patient Last Name:_____ **First Name:** _____

Birthdate:_____ **Today's Date:** _____

SCREENING QUESTIONNAIRE FOR CARDIAC DISEASES IN CHILDREN AND YOUNG ADULTS

(PLEASE HAVE PARENT ASSIST WHEN ANSWERING THESE QUESTIONS)

There are several very rare conditions that can lead to serious cardiac problems or cardiac arrest that may occur during sports or exercise programs in children or young adults. Some of these conditions cannot be foreseen or predicted by any pre-participation screening questionnaire or even a pre-participation physical exam because there may be no clues from the family history, prior symptoms, or physical exam. There are some key symptoms and family history clues that may help to direct us to obtain more specific and comprehensive cardiac studies in an effort to identify individuals who have a serious cardiac condition. Because these conditons are so rare, it is not advisable to obtain comprehensive cardiac testing on every child or young adult beginning a sport or exercise program. Accordingly, please answer the following questions and return this form back to the nurse or physician.

	PLEASE CIRCLE THE ANSWER	
Have you ever passed out during or right after exercise?	YES	NO
Do you become dizzy during or right after exercise on an ongoing basis?	YES	NO
Do you have chest pain during or right after exercise on an ongoing basis?	YES	NO
Do you hear your heart racing in an irregular manner or skipping beats on more than one occasion when not engaged in heavy exercise?	YES	NO
Do you get much more tired during exercise than others your own age and size?	YES	NO
Has any family member ever suffered a heart attack or sudden death during exercise at an early age(under 50 years)?	YES	NO
Do you have a family member diagnosed under age 50 with a cardiac rhythm disturbance(arrythmia) or an electrocardiogram abnormality?	YES	NO
Do you have a family member diagnosed under age 50 with an abnormality of the heart's muscle(cardiomyopathy)?	YES	NO
Do you have a family member with these specific conditions: prolonged QT syndrome or Marfan's syndrome?	YES	NO
Have you been told that you have a heart murmur?	YES	NO

Details:

_____

Patient Last Name: _____ First Name: _____

Birthdate: _____ Today's Date: _____

PEDIATRIC WELLNESS QUESTIONAIRE AND ACTION PLAN (AGES 2-21 YEARS)

Nutrition

Please estimate the average number of total servings per day of both fruits and vegetables:
(1 serving is about 1/2 cup)

☐1 or less ☐2 ☐3 ☐4 ☐5 or more

Goal: 5 or more servings per day fruits and vegetables is recommended.

Please estimate the average number of total servings per day of water:

☐1 or less ☐2 ☐3 ☐4 or more

Goal: 4 or more servings per day of water is recommended.

Please estimate the average number of total servings of the following:

Milk (either cow's milk or other milk substitute): ☐none ☐1 ☐2 ☐3 or more

Other dairy (i.e. cheese, yogurt, ice cream): ☐none ☐1 ☐2 ☐3 or more

Please indicate the type of milk: ☐FAT FREE ☐1% ☐2% ☐WHOLE ☐OTHER_____

Goal: 3 or more total calcium containing food/beverage servings per day is recommended for adequate daily calcium intake. If you are not meeting this requirement, then please discuss with your provider the role of calcium supplements.

Does the patient take a daily multiple vitamin? ☐YES ☐ NO

……..

Physical Activity

Please estimate the total number of average time per day spent physically active– please include any sports, gym class in school, running around, biking, active play time, or any non-sedentary activity. Averaging implies that if two hours of activity one day and none the next day, then that would average to 1 hr per day:

Approx time per day in hours: ☐Less than 1 hour ☐1 hour or more

Goal: An average of 1 hour or more per day of physical activity is recommended.

……..

Screen Time

Please estimate the average amount of time per day spent watching TV, using recreational computer, or video gaming (do not include computer time used for school or work based homework):

Approx time per day in hours: ☐Less than 2 hours ☐2 hours or more

Goal: Total recreational screen time should average less than 2 hours per day.

……..

Hypertension Counseling

Hypertension, also known as high blood pressure, is very common among adults, but can also occur in children and teenagers. Healthy lifestyles begun during childhood can help lower the risk of hypertension in adulthood, including (1) maintaining a healthy weight, (2) regular aerobic type exercise sustained all year long, (3) modest salt intake, and (4) learning to manage stress in an effective and positive manner. Another important component is regular yearly physical exams to monitor and check blood pressure beginning in childhood. Family history is also an important risk factor. Lastly, hypertension often has no symptoms and may go undetected without regular exams.

PHQ 9: Modified

Last name _____ First Name _____ Birthdate _____

Today's Date _____

How often have you been bothered by each of the following symptoms during the past two weeks?

(For each symptom put an X in the box beneath the answer that best describes how you have been feeling?)

	Not at all (0)	Several Days (1)	More than half the days (2)	Nearly every day (3)
1. Little interest or pleasure in doing things?				
2. Feeling down, depressed, irritable or hopeless?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Feeling tired, or having little energy?				
5. Poor appetite, weight loss, or overeating?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				
In the past year, have you felt depressed or sad most days, even if you felt okay sometimes? [ ] Yes [ ] No				
If you are experiencing any of the problems on this form, 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				
Has there been a time in the **past month** when you have had serious thoughts about ending your life? [ ] Yes [ ] No				
Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt? [ ] Yes [ ] No				

**If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.

Office use only - Severity Score: _____

1-4 Minimal
5-9 Mild
10-14 Moderate
15-19 Mod severe
20-27 Severe

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