OBERLIN ROAD PEDIATRICS

PATIENT

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

Your Name: ____
Your Cell Phone Number: ______________________________

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:

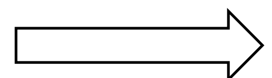
Have you ever fainted while exercising?	No	Yes
Do you typically cough or have shortness of breath when exercising? Outside of deconditioning?	No	Yes
Have you gotten aching chest pain when you exercise?	No	Yes
Has anyone in your family had a heart attack or stroke before age 55?	No	Yes
Did anyone in the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

Are you sexually active 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? □ Yes □ No

This includes running, playing sports, or doing physically active things with friends?

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

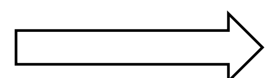
Do you have trouble sleeping at night or waking up in the morning? □ No □ Yes

Do you harm yourself, such as by cutting, hitting, or pinching yourself? □ No □ Yes

Do you 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