11-17 Year Well Check-Up

Person completing form: Mother___ Father____ Grandparent____ Other _____
Language(s) spoken at home_____

Parental Concerns: Do you have any concerns today? No__Yes__
If yes, explain_____

Relationships:
Who lives in the home with the child?_____
Number of siblings? _____
Are you coping well with your child? No____Yes____
Are you comfortable with your child? No____Yes____
Are there smokers at home? No____Yes____
If yes, do they smoke outside only? No____Yes____

TB Risk Assessment:
Known exposure to person with TB? No____Yes____
If yes, who? _____

Home Environment & Safety:
Type of dwelling: (circle one) Apartment House Trailer Other
Heat source: (circle one) Gas Electric Hot water Other
Water source for dwelling: (circle one) City/municipal Well
Known Lead exposure in home? No____Yes____
If yes, was it removed? No____Yes____
Home built before 1950? No____Yes____
Any home renovations in last 6 months? No____Yes____
Use bike/skating helmet? No____Yes____
Use seatbelt in vehicle? No____Yes____
Does your dwelling have:
Carbon monoxide detectors? No____Yes____
Smoke detectors? No____Yes____
Pool/spa at home? No____Yes____
Pets or animals at home? No____Yes____
If yes, what types? _____
Firearms in the home? No____Yes____
If yes, are they in locked storage? No____Yes____

Education:
School Name _____ Grade _____
Has your child repeated any grades in school? No____Yes____
If yes, what grade? _____
Average grades _____
Does your child like school? No____Yes____
Ever suspended or expelled? No____Yes____
If yes, please explain_____
Learning disability diagnosed/suspected? No____Yes____
Special needs in school? No____Yes____
College Prep? No____Yes____

Activity/Exercise:
Any concerns? No____Yes____
How many hours of exercise per day? _____
How many hours per day watching TV or playing video games? _____
Any organized sports/activities? No____Yes____
If yes, what types? _____

Sleep Habits:
Any concerns? No____Yes____
If yes, explain_____
Does your child sleep alone in own room? No____Yes____
Does your child sleep 8 hrs or more per night? No____Yes____

Travel:
Any recent travel out of the country? No____Yes____
If yes, where did you travel? _____

Nutrition:
Does your child drink (circle all that apply): Milk Juice Water Soda
What type of milk is given?
Whole ___2%___1%___Soy ___Almond ___Rice____
How many ounces of milk per day? _____
How many ounces of juice per day? _____
Does your child eat a healthy variety of foods? No____Yes____

Dental:
Any concerns with child's teeth? _____
Brushing teeth every day? No____Yes____
Regular visits to dentist every 6 months? No____Yes____
Any cavities? No____Yes____

Elimination:
Any concerns with urine output? No____Yes____
Any concerns with bowel movements? No____Yes____

Family History:
Is there any family history of mental illness, emotional problems, drug or alcohol abuse? If so, please describe _____
_____

Illness/Injuries/Hospitalizations/Surgeries:
Since the last well visit, has your child:
Had any injuries or admitted to the hospital? No____Yes____
Had any surgery? No____Yes____
If yes, please explain _____

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