

13-21-Year-Old Well Child Visit



Patient's Name: _____ Age: _____ Date: _____

Person completing the form _____ Relationship to the patient _____

Have you had any illnesses, hospitalizations, or surgeries since last visit here? (YES) (NO)

Nutrition:	Yes	No
Are you drinking low-fat milk, limited to no more than 2-3 cups per day?	<input type="checkbox"/>	<input type="checkbox"/>
Is juice or sugary drinks limited to 0-1 servings per day?	<input type="checkbox"/>	<input type="checkbox"/>
Do you eat a variety of fruits/vegetables/dairy/meat?	<input type="checkbox"/>	<input type="checkbox"/>
Do you regularly take a supplement that contains Vitamin D?	<input type="checkbox"/>	<input type="checkbox"/>
On average, do you eat fast food one or more times per week?	<input type="checkbox"/>	<input type="checkbox"/>
Are you satisfied with your current weight?	<input type="checkbox"/>	<input type="checkbox"/>

Family and Social History:	Yes	No
Are there any major illnesses in the family that we are not already aware of?	<input type="checkbox"/>	<input type="checkbox"/>
Are there any major stressors in the family (illness, moves, death, separation)?	<input type="checkbox"/>	<input type="checkbox"/>

Preventative Health/Risk Factors:	Yes	No
Is screen time (TV/videos/video games/computer/tablet/phone) limited to less than 2 hours a day?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a TV or internet in your bedroom?	<input type="checkbox"/>	<input type="checkbox"/>
Do you always wear a seatbelt?	<input type="checkbox"/>	<input type="checkbox"/>
Are you exposed to anyone that smokes?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear a helmet when riding a bike, skateboarding, rollerblading, etc.?	<input type="checkbox"/>	<input type="checkbox"/>
Are there any guns in the home?	<input type="checkbox"/>	<input type="checkbox"/>
• If yes, are they always kept empty and locked?	<input type="checkbox"/>	<input type="checkbox"/>
Are there smoke detectors and fire extinguishers in the home?	<input type="checkbox"/>	<input type="checkbox"/>
• Are they checked yearly?	<input type="checkbox"/>	<input type="checkbox"/>
Has your child had close contact with anyone who has tuberculosis (TB), or is at high risk for TB (visited Africa, Asia, Latin America, Caribbean Country, been homeless or jailed, IV user, HIV positive)?	<input type="checkbox"/>	<input type="checkbox"/>
Do you see a dentist twice a year and brush teeth daily?	<input type="checkbox"/>	<input type="checkbox"/>
Are you getting daily exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Are you going to need a sports form completed within the next year?	<input type="checkbox"/>	<input type="checkbox"/>

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Heart Health:	Yes	No
Do you get chest pain when you exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever pass out during or immediately after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have unexplained shortness of breath or fatigue during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Does your heart ever suddenly race (beat fast) without a good reason?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had an unexplained seizure?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been diagnosed with high blood pressure, a heart infection, high cholesterol, Kawasaki disease, or another heart problem?	<input type="checkbox"/>	<input type="checkbox"/>
Has anyone in your family <u>died suddenly</u> from a heart problem <u>before the age of 40</u> ?	<input type="checkbox"/>	<input type="checkbox"/>
Has anyone in your family <u>died suddenly</u> for an unknown reason <u>before the age of 40</u> (including sudden infant death syndrome (SIDS), unexplained car accident, or drowning)?	<input type="checkbox"/>	<input type="checkbox"/>
Does anyone in your family have any of the following <u>specific genetic heart conditions</u> : hypertrophic cardiomyopathy, dilated cardiomyopathy, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome, short QT syndrome, catecholaminergic polymorphic ventricular tachycardia (CPVT), Brugada syndrome, or Marfan syndrome?	<input type="checkbox"/>	<input type="checkbox"/>

Puberty:	Yes	No
Have you begun to have periods?	<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> If yes, are they regular? If yes, are they minimally uncomfortable? 	<input type="checkbox"/>	<input type="checkbox"/>

Academic:	Yes	No
What grade are you in? _____		
Are you scoring at or above grade level?	<input type="checkbox"/>	<input type="checkbox"/>
Do you enjoy reading?	<input type="checkbox"/>	<input type="checkbox"/>
Are you involved in extracurricular activities?	<input type="checkbox"/>	<input type="checkbox"/>
Do you receive any extra services, tutoring? PT, OT, speech therapy, etc.?	<input type="checkbox"/>	<input type="checkbox"/>

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