RISK ASSESSMENT 18-21 YEARS

DEVELOPMENT

Do you:

Have at least one responsible adult in life who cares & can go to if needed	**YES**	**NO**
Have at least one friend or group of friends whom is comfortable with	**YES**	**NO**
Have become more independent & made more self-decisions	**YES**	**NO**
Have any concerns about body image	**YES**	**NO**

Servings of fruit & vegetables per day	More than 4 per day	3-4 per day	1-2 per day	0-1 per day
Eats out each week	0-1 times	1-2 times	3-4 times	More than 4 times
Activity level	More than 60 min per day	30-60 min per day	Less than 30 min per day	Not very often
Sweet drinks per day	Not very often	1 per day	2 per day	More than 3 per day
TV/screen time	Not very often	30-60 min/d	1-2hr/d	More than 2hr/d

Vison/Hearing:

Is blackboard at school difficult to see	**NO**	**YES**
Failed School vision test	**NO**	**YES**
Do you squint	**NO**	**YES**
Do you have problems hearing over the telephone	**NO**	**YES**
Do you find yourself asking people to repeat themselves	**NO**	**YES**

TB Risk:

Were you born in a country outside the U.S.	**NO**	**YES**
Have you traveled or had contact with High Risk Tb population	**NO**	**YES**
Has a family member or contact had tuberculosis or positive skin test	**NO**	**YES**
Have you tested positive for HIV	**NO**	**YES**

Anemia risk:

Have you been diagnosed with iron deficiency anemia	**NO**	**YES**
Does your diet include iron-rich foods Such as meat, eggs, iron fortified cereal or beans	**YES**	**NO**

Risk Assessment;

Do you go to school	**YES**	**NO**	
Having any problems in school	**NO**	**Sometimes**	**YES**
Do you receive healthcare from anyone besides medical doctor	**YES**	**NO**	
Have you been to the dentist in last year	**YES**	**NO**	
Do you protect your ears when around loud noises	**YES**	**NO**	
Do you live in parent's home	**YES**	**Sometimes**	**NO**
Involved in your community with an issue that concerns or interests you	**YES**	**NO**	
Do you eat meals together as a family at least once a week	**YES**	**NO**	
Always wears a seat belt when riding in car, truck, or van	**YES**	**Sometimes**	**NO**
Wears helmet/pads when biking, skating, skiing or snowboarding	**YES**	**Sometimes**	**NO**
Do you ever use a cell phone or headphones when driving	**YES**	**Sometimes**	**NO**
Do you get along with your family	**YES**	**NO**	

Cardiac Risk: Have you ever had:

Fainting during or after exercise, emotion or startle?	**NO**	**YES**
Extreme shortness of breath with exercise?	**NO**	**YES**
Discomfort, pain, or pressure in chest during exercise?	**YES**	**NO**

The Patient Health Questionnaire-2 (PHQ-2)

Patient Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3