Patient Name_____DOB_____

RISK ASSESSMENT 18-21 YEARS

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**

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

Patient Name _____Date _____

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**	

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**	

Current Patient Check Up Form (18 yrs – 21 yrs)

Date _____

Patient Name _____D.O.B. _____

Current problems/Concerns _____

Allergies (Medications, Vaccines, Food, others)_____

Current Medications _____

CHILD'S PAST MEDICAL HISTORY

Since your child's last check up, has she or he had:

	Yes	**No**
Hospitalizations?	☐	☐
Surgeries?	☐	☐
Emergency room or urgent care visits?	☐	☐

If yes to any of the above questions, please explain?

_____

Does your child see the eye doctor regularly?	☐	☐
Does your child visit the dentist regularly?	☐	☐

Has your child ever been treated for any of the following?

	Yes	**No**
ADHD/ADD	☐	☐
Allergies	☐	☐
Asthma	☐	☐
Eczema	☐	☐
Seizures	☐	☐
Heart Murmur	☐	☐
Wheezing	☐	☐
Pneumonia	☐	☐
Ear Infections	☐	☐
Urinary tract infection	☐	☐
Acne	☐	☐
Serious injury or concussion	☐	☐
Developmental and/or speech problems	☐	☐
For girls only, has she started her menstrual cycle?	☐	☐

Other history of chronic problem?_____

Has your child ever been seen by a specialist? _____ If so, please describe?

_____

Has your child ever had:	**Yes**	**No**
Fainting during or after exercise, emotion or startle?	☐	☐
Extreme shortness of breath with exercise?	☐	☐
Discomfort, pain, or pressure in chest during exercise?	☐	☐

FAMILY HISTORY **Patient Name_____**

Do any family members have any of the following conditions?

Condition	Mother	Father	Sibling	Grandparent
High Blood Pressure	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐
Prolonged QT	☐	☐	☐	☐
Early heart attack (under 50 yrs. old)	☐	☐	☐	☐
Sudden unexplained death	☐	☐	☐	☐
Anemia	☐	☐	☐	☐
Bleeding or clotting disorder	☐	☐	☐	☐
Allergies	☐	☐	☐	☐
Autoimmune disorder	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Development/genetic disease	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐
Polycystic Ovarian Syndrome	☐	☐	☐	☐
Ear tubes	☐	☐	☐	☐
Deafness	☐	☐	☐	☐
Stomach problems	☐	☐	☐	☐
Liver disease	☐	☐	☐	☐
Celiac disease	☐	☐	☐	☐
ADD/ADHD	☐	☐	☐	☐
Migraines	☐	☐	☐	☐
Autism	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Mental illness	☐	☐	☐	☐
Drug/alcohol abuse	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐
Kidney problems	☐	☐	☐	☐
Lazy eye	☐	☐	☐	☐
Hip dysplasia	☐	☐	☐	☐
Other	☐	☐	☐	☐

Who lives in your child's home? _____

If parents are not living together or if child does not live with parents, what is the child's custody status?

_____

Is your child in: School? _____ If so, what grade? _____

Do you have any concerns about school performance? _____

_____

Any changes to your home life? (death, divorce, social stress?) _____

Do you have any special concerns today?

_____

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