**Well-Care Questionnaire**  
for teens aged 13 to 17

**WORKSHEET TO BE COMPLETED BY TEEN:** This worksheet can give your health care team information to help you take better care of yourself. You don’t have to answer any questions you don’t want to. Kaiser Permanente values your privacy. Your answers will be kept confidential.

<table>
<thead>
<tr>
<th>Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confidential phone number:</td>
</tr>
<tr>
<td>Is it okay to leave a message?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What are your MAIN REASONS for today’s visit?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical exam</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>For clinic use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Complaint</td>
</tr>
</tbody>
</table>

**Family, School, and Other Activities**

Who are the people that live with you (include names, ages, relationships):

<table>
<thead>
<tr>
<th>Are you in school?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If YES: What grade are you in? Which school do you go to?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you having a hard time in school?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

In a typical month, how often do you:

**Miss a class or day of school?**

**Skip a class or day of school?**

<table>
<thead>
<tr>
<th>Do you have a job outside of school?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If YES: Do you work at this job more than 20 hours a week?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

What sports, activities, and hobbies are you involved in?

**Medications**

What medicines are you taking, including prescription, herbal, and over-the-counter?

**Medical History – check box if you have, or ever had, any of the following:**

<table>
<thead>
<tr>
<th>Allergies</th>
<th>Diabetes</th>
<th>Mental health problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>Heart problems</td>
<td>Seizure/epilepsy</td>
</tr>
<tr>
<td>Depression/anxiety</td>
<td>Learning disability/ADHD</td>
<td>Sexually transmitted disease (STD)</td>
</tr>
</tbody>
</table>

List major illnesses, operations, hospitalizations, injuries, or conditions (describe and give year):

**Family History**

Check here if you know you were adopted

Please check boxes below if you have any family members who have had any of following: Which family members?

<table>
<thead>
<tr>
<th>Alcohol/drug problems</th>
<th>Asthma/allergies</th>
<th>Cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression/suicide</td>
<td>Diabetes</td>
<td>Other illnesses/conditions</td>
</tr>
</tbody>
</table>

**Sports**

<table>
<thead>
<tr>
<th>Have you ever:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Passed out or nearly passed out while exercising?</td>
</tr>
<tr>
<td>Had discomfort, pain, tightness or pressure in chest while exercising?</td>
</tr>
<tr>
<td>Had your heart race or skip beats while exercising?</td>
</tr>
<tr>
<td>Felt lightheaded or shorter of breath than expected while exercising?</td>
</tr>
<tr>
<td>Had an explained seizure?</td>
</tr>
<tr>
<td>Been more tired or short of breath than your friends while exercising?</td>
</tr>
<tr>
<td>Had heart problems?</td>
</tr>
<tr>
<td>Been knocked out or had a concussion?</td>
</tr>
<tr>
<td>Broke a bone, or had a dislocation or other significant sports injury?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Do you have any of the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family member who died suddenly before the age of 50?</td>
</tr>
<tr>
<td>Family history of heart problems?</td>
</tr>
<tr>
<td>Family history of unexplained fainting, seizures, or near drowning?</td>
</tr>
</tbody>
</table>

**Flow Staff Note**

**Provider Note**

**History: Social Documentation**

**History: Medical/Surgical**

**History: Family**

**Medications**

**DO NOT FILE IN MEDICAL RECORD**

Continued on next page
### Nutrition
- **Do you eat fruits and vegetables every day?**
  - Yes
  - No
- **Do you eat or drink dairy products?**
  - Yes
  - No
- **Are you a vegetarian?**
  - Yes
  - No
- **Do you have any questions or concerns about your eating habits?**
  - Yes
  - No

### Safety
- **If you ride a motorcycle or bicycle, do you always use a helmet?**
  - Yes
  - No
- **Do you always use your seat belt when in a car?**
  - Yes
  - No
- **Do you ever drive or ride with a driver who is under the influence of alcohol or drugs?**
  - Yes
  - No
- **Do you or any of your friends have access to guns?**
  - Yes
  - No
  - Don't know
- **Has anyone ever hit or touched you in a way that made you uncomfortable or afraid?**
  - Yes
  - No

### Family and Peers
- **Do you get along with your family?**
  - Yes
  - No
- **Are you having a hard time at home?**
  - Yes
  - No
- **Do you have a friend you can talk to about any problems you have?**
  - Yes
  - No
- **Are you having trouble with fighting or bullying?**
  - Yes
  - No
- **Are you feeling pressure to do what others are doing?**
  - Yes
  - No

### Stress and Depression
- **During the past 2 years, have you or anyone in your family had any major good or bad changes?**
  - Yes
  - No
- **Do you have any concerns about your body or weight?**
  - Yes
  - No
- **Do you ever eat in secret or feel guilty about eating?**
  - Yes
  - No
- **Have you recently lost interest or pleasure in doing things?**
  - Yes
  - No
- **Have you been feeling down, depressed, irritable, or hopeless?**
  - Yes
  - No

### Tobacco, Nicotine, and Vapor
- **Have you ever used tobacco (smoke, chew, e-cigarettes) or other vapor product?**
  - Yes
  - No

### Alcohol, Marijuana, and Other Drugs
- **During the past 12 months:**
  - Did you drink any alcohol (more than a few sips)?
    - Yes
    - No
  - Did you smoke any marijuana or hashish?
    - Yes
    - No
  - Did you use anything else to get high?
    - Yes
    - No
  - Have you ever ridden in a car driven by someone (including yourself) who was ‘high’ or had been using alcohol or drugs?
    - Yes
    - No

### Sexuality
- **Are you attracted to**
  - Males
  - Females
  - Both
  - Not sure
- **Have you ever had sex?**
  - Yes
  - No
- **When you have sex, how often do you use a condom?**
  - Always
  - Sometimes
  - Never
- **When you have sex, how often do you, or does your partner, use protection from pregnancy other than a condom?**
  - Always
  - Sometimes
  - Never
  - Doesn’t apply to me
- **Have you ever been pregnant or made someone pregnant?**
  - Yes
  - No
- **Have your periods started?**
  - Yes
  - No
- **Are they regular?**
  - Yes
  - No
- **Do menstrual cramps keep you from doing your normal activities?**
  - Yes
  - No

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**NOT TO BE FILED IN THE MEDICAL RECORD**