

Name: _____ DOB: _____ Today's Date: _____

FIFTEEN YEAR WELL CHILD CHECK

INTERVAL / BEHAVIOR / DEPRESSION / DEVELOPMENT

| | |
|--|--|
| Any new changes in your life since last year? Do you have special health care needs? | <input type="checkbox"/> No <input type="checkbox"/> Yes, describe: <input type="checkbox"/> No <input type="checkbox"/> Yes, describe: |
| Any concerns about your behavior? | <input type="checkbox"/> No <input type="checkbox"/> Yes, describe: |
| In the last 2 weeks, how often have you had: Little interest or pleasure in doing things Feeling down, depressed, or hopeless | <input type="checkbox"/> Not at all <input type="checkbox"/> Several days <input type="checkbox"/> More than half the days <input type="checkbox"/> Nearly everyday <input type="checkbox"/> Not at all <input type="checkbox"/> Several days <input type="checkbox"/> More than half the days <input type="checkbox"/> Nearly everyday |
| <input type="checkbox"/> I eat healthy, exercise, & keep myself safe. <input type="checkbox"/> I have a friend or a group who I feel comfortable with. <input type="checkbox"/> If something bad happens in life, I can get back on my feet. <input type="checkbox"/> I have hope and confidence in myself. <input type="checkbox"/> I feel I am good at something (like math, soccer, cooking, etc). <input type="checkbox"/> I help others on my own or with a church, school, or club. <input type="checkbox"/> I feel there is an adult who cares for me who I can go to for help. <input type="checkbox"/> I'm more independent and make more decisions on my own. | |

ANEMIA / TB / CHOLESTEROL / FLUORIDE / SUBSTANCE / DEPRESSION / STD RISK ASSESSMENT

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|---|---|
| Have you ever been diagnosed with iron deficiency anemia? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Does your diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| If you are female, do you have heavy periods or periods that last more than 5 days? | <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A |
| Were you born in a country where tuberculosis is prevalent (outside the US)? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have you traveled (>1 week) to a country at high risk of tuberculosis? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have you had contact with anyone with tuberculosis or a positive PPD test? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have you ever been in jail? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Do you have HIV? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Do you have parents or grandparents who've had stroke or heart problems before age 55? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Do you have parents with high cholesterol (>240 mg/dL) or taking cholesterol medication? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Does your primary water source have fluoride (i.e. city water)? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Do you smoke cigarettes, cigars, hookah, or other tobacco products? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| In the past year, did you drink alcohol (more than a few sips)? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| In the past year, did you smoke weed or other drug to get high? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have you ever driven or been driven in a car by someone who was using alcohol or drugs? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| If you use alcohol or drugs, do you use it to relax, feel better about yourself, or fit in? | <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A |
| If you use alcohol or drugs, do you use it alone, by yourself? | <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A |
| If you use alcohol or drugs, do you forget things you did while using it? | <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A |
| If you use alcohol or drugs, do your family or friends tell you you should cut down or quit? | <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A |
| If you use alcohol or drugs, do you ever get into trouble while using alcohol or drugs? | <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A |
| Have you ever used injectable drugs (like cocaine, heroin, meth through needles)? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have you ever had sex (including oral)? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have any of your past or current sex partners been infected with HIV or was injectable drug user? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have you ever been treated for a sexually transmitted disease? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have you had unprotected sex (without a condom)? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Do you trade sex for money or drugs or have sex partners who do? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have you ever had sex with men who've had sex with other men? | <input type="checkbox"/> No <input type="checkbox"/> Yes |

ANTICIPATORY GUIDANCE:

- Visit the dentist at least twice a year. Brush your teeth at least twice a day and floss once a day.
- Drink water instead of soda, Kool-Aid, gatorade, sweet tea, juices, or other sugary drinks. Exercise at least 1 hour per day.
- Protect yourself from hearing loss. Don't blast music on headphones. Wear ear plugs in loud places or when mowing lawn.
- Spend no more than 2 hours a day on TV, video games, phone, tablet, or computer (outside of homework time).
- Talk with your parents about alcohol, drugs, smoking, driving, and sex. Make the right choices for yourself.
- Drinking and driving is dangerous and not cool, and don't get into a car with someone who does this.
- Learn to handle conflict without violence. Be proud of yourself when you do something good.
- Only go out with people who respect you. It is ok to say "no" to your date.
- Feel free to talk with us if you have any questions about gender identity and sexual orientation. It's ok to be who you are.
- Set high goals for yourself in school, your future, and other activities, and work hard to achieve them. It will pay off.