

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_

### SEVENTEEN 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 live a healthy lifestyle: 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 my life, I'm able to 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.	

#### VISION / HEARING / ANEMIA / TB / CHOLESTEROL / SUBSTANCE / STD RISK ASSESSMENT

Do you complain that the blackboard has become difficult to see? Have you ever failed a school vision screening test? Do you hold books close to your eyes to read? Do you have trouble recognizing faces at a distance Do you tend to squint?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes
Do you have a problem hearing over the telephone? Do you have trouble following the conversation when 2 or more people are talking at the same time? Do you have trouble hearing with a noisy background? Do you find yourself asking people to repeat themselves? Do you misunderstand what others are saying and respond inappropriately?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes
Have you ever been diagnosed with iron deficiency anemia? Does your diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans? 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"/> No <input type="checkbox"/> Yes <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)? Have you traveled (>1 week) to a country at high risk of tuberculosis? Have you had contact with anyone with tuberculosis or a positive PPD test? Have you ever been in jail? Do you have HIV?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes
Do you have parents or grandparents who've had stroke or heart problems before age 55? Do you have parents with high cholesterol (>240 mg/dL) or taking cholesterol medication?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes
Do you smoke cigarettes, cigars, hookah, or other tobacco products? In the past year, did you drink alcohol (more than a few sips)? In the past year, did you smoke weed or other drug to get high? Have you ever driven or been driven in a car by someone who was using alcohol or drugs? If you use alcohol or drugs, do you use it to relax, feel better about yourself, or fit in? If you use alcohol or drugs, do you use it alone, by yourself? If you use alcohol or drugs, do you forget things you did while using it? If you use alcohol or drugs, do your family or friends tell you you should cut down or quit? 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"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A <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)? Have you ever had sex (including oral)? Have any of your past or current sex partners been infected with HIV or was injectable drug user? Have you ever been treated for a sexually transmitted disease? Are you having unprotected sex (without a condom)? Do you trade sex for money or drugs or have sex partners who do? Have you ever had sex with men who've had sex with other men?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <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.
- Protect yourself from hearing loss. Don't blast music on headphones. Wear ear plugs in loud places or when mowing lawn.
- Drink water instead of soda, Kool-Aid, gatorade, sweet tea, juices, or other sugary drinks. Exercise at least 1 hour per day.
- 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.
- 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.