

Four Seasons Pediatrics
Well Visit Form for Adult Well Visit

Child's Name: _____ Birth Date: _____ Age: _____
Today's Date: _____

Any change in address, if so list new information:

General Questions:

Please check off what best describes you:

In school full time – Name of school: _____

Working full time – Occupation: _____

Other – describe: _____

Please make a check if the following statements are true:

I attend loud concerts, ear buds frequently or hear loud noises

I do not wear my seatbelt

I have access to a gun

I am worried about violence or my safety

I have been in trouble with the police

I am not happy about my weight

I skip meals, or have taken medications to reduce my weight

I currently smoke

I have tried beer, wine or other liquor

I drink alcohol regularly

I have used street drugs

I am worried about drugs or alcohol use of someone who lives in my home

I would like to get counseling about something that is bothering me

In the past few weeks, I have been very sad, depressed or felt I have nothing to look forward to

I have had thoughts of harming myself or committing suicide

I have been abused in the past

I have been forced to do something sexual against my will

I am worried about pregnancy

I am worried about sexually transmitted diseases

I am in need of birth control

Screening – Please check the box if any of the following are true:

I have been exposed to tuberculosis or a person with a positive skin test

There is a family history of high cholesterol of > 240 in either parent or grandparents

There is a family history of heart disease before 55 in either parent or grandparents