

## Four Seasons Pediatrics

Well Visit Form for 12 Year to 17 Year Well Visit

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Today's Date: \_\_\_\_\_

### Please check off all that are true about your teenager:

- Relates well to me
- Relates well to siblings
- Is performing well in school. Current GPA is: \_\_\_\_\_  
What does he/she plan to do after high school? \_\_\_\_\_
- Accomplishes assigned chores reasonably
- Holds a part time job
- Spends most free time with other teenagers
- Popular with peers
- Usually a happy person
- Shows an interest and pleasure in things
- He/She is developing a good self image
- I approve of his/her friends
- He/She communicates with me concerning frustrations and bad feelings  
Is there any aspect of sex education and/or behavior you would like us to discuss with your child?  
If yes, please explain: \_\_\_\_\_
- Absent from school for less than 2 days each month
- Has not expressed concerns for dropping out of school
- No conduct problems in school
- Do not have to discipline him/her frequently
- To my knowledge, he/she has not tried any drugs, nor has anyone in the household
- Is not sexually active to my knowledge
- Does not show signs of being down, depressed or hopeless
- Shows interest and or pleasure in activities of interest
- There are no recent marital problems that may affect my teenager
- There is no contemplation of an upcoming parental separation or divorce
- The family is not under any significant serious stresses or mental health concerns. If yes, describe:  
\_\_\_\_\_
- There are no concerns about firearms or none in the home

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

- My child has had exposure 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

### Social:

Do you have any concerns about meeting your daily needs, paying for medications, household income, food or housing, crime or other social and economic issues? \_\_\_\_\_

Does anyone in the family have any vision, hearing or cognitive problems that would hinder communication with the medical provider? \_\_\_\_\_

### Vaccine Information Statements (Check One)

- I will review the in-room copy
- I will review the on-line copy at your website
- I would like a paper copy

# Four Seasons Pediatrics – Young Adult Questionnaire

Patient Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Age: \_\_\_\_\_ Years

**This information will not be shared with anyone (including your parents) without your permission. Please complete this form on your own. Today's provider will go over the answers with you.**

The questionnaire is to be used during your visit. Please carefully answer each question "Yes" or "No"

- YES NO 1. Do you get along well with your parents?  
YES NO 2. Do you get along well with your brothers and sisters?  
YES NO 3. Do you have chores at home?  
YES NO 4. Do you have a part time job?  
YES NO 5. Are you satisfied with your personal relationships, daily activities and social interactions with others your age?  
YES NO 6. Do you have a close friend?  
YES NO 7. Are you doing OK in school? What is your average grade? \_\_\_\_\_  
YES NO 8. Is life going OK for you?  
YES NO 9. Do you feel your parents are fair about discipline?  
YES NO 10. Do your parents get along well with each other?  
YES NO 11. Are you involved or participate in church or other religious observance?  
YES NO 12. Do you like to have friends visit your home?  
YES NO 13. Do you do any volunteer or community service?  
YES NO 14. Do you have someone you can talk over problems or frustrations with?  
YES NO 15. Do you wear a seat belt?  
YES NO 16. Would you wear a bike helmet if you got on a bike?  
NO YES 17. Do you feel nervous, anxious or on edge?  
NO YES 18. Do you feel that you have a hard time stopping or controlling worry?  
NO YES 19. Do you feel down, depressed or hopeless?  
NO YES 20. Do you find you have little interest or pleasure in things you do?  
NO YES 21. Have you recently felt like doing harm to yourself or ever contemplated suicide?  
NO YES 22. Are you sexually active or have questions about sex that you would like to ask about?  
NO YES 23. Do you miss more than 2 days of school each month?  
NO YES 24. Are you thinking about dropping out of school?  
NO YES 25. Have you recently been in trouble with the law?  
NO YES 26. Is your family under any serious stress?  
NO YES 27. Is there any possibility of recent separation or divorce in your family?  
NO YES 28. Do you have any concerns about your weight, nutrition, or oral health/dental care ?  
NO YES 29. Do you smoke or are you exposed to second hand smoke? (circle which one if positive)  
NO YES 30. Do you consume any alcoholic beverages, drugs or use anything else to get high?  
NO YES 31. I would like to be tested for STDs, such as Chlamydia or GC?

32. Some things that my parents do that upset me are: \_\_\_\_\_

33. When my parents are upset with me they: \_\_\_\_\_

34. Things that I like to do in my free time: \_\_\_\_\_

35. What sports do you participate in? \_\_\_\_\_

36. List any concerns that you would like to discuss during your appointment: \_\_\_\_\_

# The Adolescent Times



18<sup>th</sup> Visit

13-15 Years

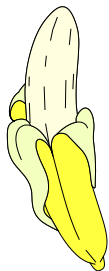
## Injury Prevention



The most common cause of death in adolescents:

- **Homicide:** Is the #1 killer of teens. Do not use or carry weapons. Learn to solve conflict without violence. Talk it over, walk away.
- **Auto Accidents:** Are the #2 killer of teens. Wear a seat belt while driving or riding. Never drive or allow others to drive after drinking. Do not ride with a driver who has been drinking.

## Nutrition - Exercise



Eat 3 meals a day. Don't forget breakfast. It is still very important to eat 3 servings of vegetables and 2 servings of fruits per day.

- If you are on the run, try: bread, bagels, crackers with peanut butter or cheese, bananas, apples,

oranges, carrots, veggies, milk, yogurt, and juice.

- Young women should have a diet with sufficient calcium – two to three servings of dairy daily. If you cannot tolerate dairy, speak with us. Females also need more iron, due to menstrual blood loss. You may want to take a multi-vitamin.

Remember the following recommendations for a healthy body:

- 5 servings of fruits/veggies per day
- 2 hours of screen time per day (TV, Video, Computer)
- 1 hour of physical activity per day (that increases heart rate)
- 0 intake of sweetened beverages

## Healthy Habits



Stay drug free and respect the decision of others to do so. Talk to us about any questions you have about steroids, alcohol, tobacco, diet pills, drugs or concerns about your weight.

## Sexuality

The decision to have sex is a serious one. Consequences can change your life permanently (pregnancy, AIDS, diseases, and depression). Not having sex is the safest choice. Express your affection by kissing, touching, and hugging. Be clear in your own mind what you do not want to do. If any part of you says no, the answer is NO. Unsafe sex includes unprotected contact between genitals, (including intercourse), genitals and the mouth (oral sex), or genitals and the anus. Safer (but not risk free) sex includes using a condom and using birth control. Condoms and birth control do not always protect you from pregnancy or sexually transmitted diseases, including AIDS.

Date rape is when someone you know forces you into sexual activity against your will. This could happen if you choose to participate in some intimate activity like kissing, but want to stop and your partner will not let you. Avoid this situation by:

- Meeting in places where there are more than just the two of you.
- Saying “no” loudly and keep saying “no” until your date stops. Be assertive.
- Making a scene so someone will help you.
- Remember you are in better control of an intimate situation if you are not using drugs or alcohol.

## Body Piercing

We do not advise body piercing or tattoos, but if you are considering these, know what you are doing. The most common site for piercing is the ear. Some people choose one ear lobe or many piercings that encircle the whole ear lobe. Other sites include eyebrows, nose, lips, tongue, nipples, navel, or even the genital areas.

### Have a checklist that can help you make sure it's what you want:

- Tetanus shot in the last 10 years?
- Completed the Hepatitis B vaccine series (3 shots)?
- Allergies to metal?
- Willing to have a permanent hole or scar on your body?

### Other Questions:

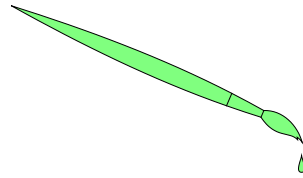
- **Sites:** Exposed sites, like the face or ear, heal faster (4-6 weeks). Navel, nipple and other areas are infected more easily because healing can take up to 4-5 months. Clothing over the area can cause irritation and promote infection and scarring.
- **Type of Jewelry:** Many people are allergic to nickel. Surgical steel and 14K gold, niobium, or titanium have smooth surfaces and are commonly used. If you get an O or U shape, they are only removable by the piercer. Find out how much it costs. Piercing is one expense and the jewelry is another.
- **What are the other risks:** The procedure is not painless and an anaesthetic is not always used. The potential exists for infection with HIV/AIDS, Hepatitis B, and Tetanus. The piercer should wear

NEW latex gloves to protect both of you. They should also use disposable or sterilized instruments. After the piercing, watch for redness, swelling, or crusty drainage from the site. If it looks infected, contact the piercer, or us, right away. If you wait too long, you could get a serious infection or scarring.

➤ **NEVER PIERCE YOUR OWN BODY OR LET A FRIEND DO IT!**

## Tattooing

The tattoo artist uses a stainless steel needle, puncturing the skin more than 3,000 times a minute.



Using one or several needles at a time, colored ink is pushed under the skin. Fresh tattoos appear very crisp, but in time they tend to fade or get hazy. Chronic sun exposure can also fade or distort the image.

### What you need to know:

- In New York, getting a tattoo is regulated by state law, and requires parental permission under the age of 18.
- The transmission of Hepatitis B or HIV by un-sterilized tattoo needles is a major concern. There are no standard guidelines for tattoo parlors to assure that diseases such as HIV and Hepatitis B are not passed from one person to another on the needles. Tattoos done by a professional, however, under hygienic conditions, generally have a lower, but not risk free chance of infection or other complications.
- If you want a tattoo, make sure you want it for the rest of your life. The design you decide on today

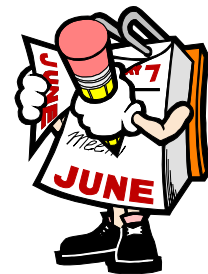
## The Adolescent Times

will be the one you and those you live with will look at for the rest of your life.

- It is very painful and expensive to have a tattoo removed. Removal of a tattoo is not covered by your insurance.
- Consider the following:
  1. Does the tattoo parlor use disposable needles?
  2. Does the tattoo parlor use

separate, disposable inks?

3. Are you allergic to any inks, especially black India ink?
4. Are you immunized against Tetanus and Hepatitis B?



## Next Visit

Please make your next check up for 1 year from today.

Please register at our website at:

[www.fourseasonspediatrics.com](http://www.fourseasonspediatrics.com)

Receive email alerts including when the flu shot arrives.