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