Four Seasons Pediatrics

Well Visit Form for Adult Well Visit

Name: _____ Birth Date: _____ Age: _____

Today's Date: _____

General Questions:

Please check off what best describes you:

- ☐ In school full time – Name of school: _____
- ☐ Working full time – Occupation: _____
- ☐ I identify my gender as a: _____
- ☐ 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 seat belt
- ☐ 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 alcohol (more than a few sips)
- ☐ I drink alcohol regularly
- ☐ I smoke marijuana
- ☐ I have used another substance to get high
- ☐ I am worried about drugs, mental health or alcohol use of someone who lives in my home
- ☐ I feel nervous, anxious or on edge
- ☐ I am not able to stop or control my worry
- ☐ 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
- ☐ In the past few weeks, I have lost interest and pleasure in things I usually enjoy
- ☐ 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 would like to be tested for 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

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