UW Medicine
UW NEIGHBORHOOD CLINICS

13-15 Year Old Female Well Child Visit

Name _____ Birth Date _____

Please fill out the following questionnaire. It will allow the provider to focus on your main concerns during the visit, and allow more time for discussion.

Review of Nutrition	**Yes**	**No**
Do you eat well-balanced diet, including fruits, vegetables, milk, and vitamins?	( )	( )
Do you see a dentist twice a year?	( )	( )
Do you brush her/his teeth 2 times daily and floss daily?	( )	( )
Do you get 60 minutes of physical activity per day?	( )	( )
Do you limit screen time (TV, video games, computer) limited to <2 hours per day?	( )	( )
Are you satisfied with your current weight?	( )	( )
Is your family free of heart attacks and strokes in people younger than 55?	( )	( )

Elimination	**Yes**	**No**
Are your bowel movements regular and comfortable?	( )	( )

Sleep	**Yes**	**No**
Do you sleep well, without snoring often?	( )	( )
Are you well-rested during the day?	( )	( )

Menstrual Cycle	**Yes**	**No**
Have your periods started yet? If so, when? _____	( )	( )
If so, are they regular and causing minimal pain?	( )	( )
Do they last 5 or less days most of the time?	( )	( )

Tuberculosis (TB) risk?	**Yes**	**No**
Have you had contact with a person who has tuberculosis?	( )	( )
Are you immuno-suppressed (HIV, cancer, chronic steroids)?	( )	( )
Birth or travel to endemic Tuberculosis areas (Africa, Asia, Latin America, Caribbean)	( )	( )
Regular contact with adults at high risk for TB (Homeless, Jailed, Illegal drug user, HIV positive person, migrant farm worker, nursing home resident)	( )	( )

Have you had any significant illnesses since the last time we saw you? If yes, please describe:

_____

Are there any new stresses on your family since the last time we saw you? If yes, please describe:

_____

Current concerns not listed above:

_____

_____