

MUNDELEIN PEDIATRICS

12-21 Year Well Exam (Female)

Name: _____ DOB: ____/____/____ Today's Date: ____/____/____

Please circle the answer that most appropriately describes your child:

- 1. Sleeps through the night: Yes/No Concerns: _____
(____) hours per night
- 2. Good eating habits: Yes/No Concerns: _____
- 3. Urinating well: Yes/No Concerns: _____
- 4. Normal bowel movements Yes/No Concerns: _____
- 5. Takes Vitamins: Yes/No Product Name: _____
- 6. Emergency room visits: Yes/No
- 7. Illness since last visit: _____
- 8. Grade level in school: _____; Concerns with school performance _____
- 9. Extra-Curricular activities: Yes/No
- 10. Participates regularly in exercise: Yes/No
Any history of sports injury or concussion: Yes/No
- 11. Regular menstrual period: Yes/No Last menstrual period: _____
- 12. Any alcohol use: Yes/No Any tobacco/drug use: Yes/No Sexually active: Yes/No
- 13. Developmentally: appropriate peer interactions, fair-good writing skills, good hand-eye coordination, good physical coordination

Please circle the answer that most appropriately describes your home environment:

- 1. Smoke-free home and car: Yes/No
- 2. Parent smokes outside: Yes/No Mom/Dad/Sibling/Relative/Babysitter
- 3. Fire arms at home: Yes/No If yes, are safety precaution taken: Yes/No
- 4. Television /Video game time: Hours per day: _____
- 5. Always uses a seat belt when riding in a car: Yes/No
- 6. Uses helmet when riding bike, skates and scooters Yes/No
- 7. Supervised after school None/Parent/Relative/After-school club/Babysitter
- 8. Primary care taker: Mom/Dad/Grandparents
- 9. Household composition: _____
Adult(Names/Ages): _____
Children(Names/Ages): _____
- 10. New health problems in parents or siblings: _____
- 11. Dental Visits Yes/No
- 12. Past vaccine reactions: Yes/No
- 13. Sibling rivalry: Yes/No

Do you have any other concerns you wish to discuss? Yes/No

