Appt Date_____ 15 year Check Up

Patient Name_____ DOB_____
Name of person filling out form _____ Phone number_____

Nutrition:

How many cups of milk do you drink per day? _____
How many cups of juice do you drink per day?_____
How many cups of water do you drink per day?_____
How many cups of soda do you drink per day?_____
Do you eat a variety of meats, fruits, and vegetables each day?_____

Bowel/Bladder:

Any concerns about your voiding or stooling?_____

Sleep:

How many hours do you sleep at night? _____

Hearing/ Vision:

Any concerns about your hearing or vision?_____

Social hx:

How much screen time does you get each day? _____
What school do you attend?_____ What grade?_____
Do you do well in school?_____ Any concerns?_____
What activities/hobbies do you enjoy?_____

Advice and Guidance for the Patient: *(please check off as you read)*

___ Safety: Always use seatbelts when riding in a car. Practice safe driving habits.
___Do not to use tobacco, alcohol, other drugs, or participate in sexual activities. Avoid situations in which alcohol and drugs are readily available. Have positive and open conversations about these issues with your parents. If you do drink, do not drive while under the influence of alcohol.
___Wear SPF 30 or greater for sun exposure
___Be sure to floss daily and brush your teeth at least twice a day. Regular dental exams are important.
___Minimize your exposure to cigarette smoke
___Does anyone smoke inside your home, including the basement or garage? Y___ N____; If yes is he/she interested in quitting? Y____ N____
___Limit screen time (TV, computer, video games) to no more than 2 hours per day.
___You should participate in at least 30-60 minutes of physical activity every day.
___Nutrition: You should have at least 3 servings of dairy every day for calcium, limit sugar drinks, and choose nutritious foods and snacks. Packing your lunch for school is also encouraged.
___ Sleep: You should have at least 9 hours of sleep every night.
___ Behavior: Abide by your parents' rules and expectations. Try to work through solutions to problems and make appropriate decision, go to your parents for advice if needed.

1. Do you have any questions or concerns to address with the doctor?
   _____
   _____
   _____
2. Do these concerns need to be addressed privately? _____

Pediatric Symptom Checklist—Youth Report (Y-PSC)

Please mark under the heading that best fits you:

		Never	Sometimes	Often
1. Complain of aches or pains	1			
2. Spend more time alone	2			
3. Tire easily, little energy	3			
4. Fidgety, unable to sit still	4			
5. Have trouble with teacher	5			
6. Less interested in school	6			
7. Act as if driven by motor	7			
8. Daydream too much	8			
9. Distract easily	9			
10. Are afraid of new situations	10			
11. Feel sad, unhappy	11			
12. Are irritable, angry	12			
13. Feel hopeless	13			
14. Have trouble concentrating	14			
15. Less interested in friends	15			
16. Fight with other children	16			
17. Absent from school	17			
18. School grades dropping	18			
19. Down on yourself	19			
20. Visit doctor with doctor finding nothing wrong	20			
21. Have trouble sleeping	21			
22. Worry a lot	22			
23. Want to be with parent more than before	23			
24. Feel that you are bad	24			
25. Take unnecessary risks	25			
26. Get hurt frequently	26			
27. Seem to be having less fun	27			
28. Act younger than children your age	28			
29. Do not listen to rules	29			
30. Do not show feelings	30			
31. Do not understand other people's feelings	31			
32. Tease others	32			
33. Blame others for your troubles	33			
34. Take things that do not belong to you	34			
35. Refuse to share	35			