15-20 Year Health Maintenance Form

student to complete

Patient Name ____

What School do you attend? ____

What grade are you in/entering? ____

How are your grades in school? circl e all that apply As Bs Cs Ds Fs

How often do you miss school? circle o ne
- Rarely or never
- 1-2 time per semester
- Once a month or more

What activities/sports/clubs are you involved in? ____

What do you do in your free time? ____

How often do you exercise? circle one
- Daily
- 3-4 times per week
- 1-2 times per week
- Less than once per week

How many hours do you sleep at night, on average? ____

Do you wear contacts or glasses? circle one No Contacts Glasses

Do you wear your seat belt? Yes No

Are you concerned about your weight? Yes No

Are you doing anything to change your weight? Yes No

If so what? ____

Do your friends smoke, drink alcohol or use drugs? Yes No

Have you ever tried smoking? Yes No

Have you tried illegal drugs? Yes No

Have you ever tried alcohol? Yes No

Turn Over Please

If you do not understand any of these questions, please ask your nurse.

Have you ever talked to your parents/guardians about dating and sex? Yes No

Have you ever had sex? Yes No

Do you ever feel unsafe at home or at school? Yes No

Do you ever have thoughts about hurting yourself or that life isn't worth living? Yes No

Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not At All	Several Days	More than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things:	0	1	2	3
2. Feeling down, depressed or hopeless:	0	1	2	3

Who do you usually talk to when you have a problem or concern?

____

Have you ever fainted? Yes No

Have you ever fainted during exercise? Yes No

Have you had chest pain during exercise? Yes No

Has anyone in your family died suddenly? Yes No

Before age 35? Yes No
Before age 50? Yes No

If “yes” to either of the above, what was cause of death and relationship to patient?

____

Have you ever had a concussion, loss of consciousness, been knocked out or had a head injury? Yes No

If yes how many times? ____

Have you ever had heat stroke or heat exhaustion? Yes No

Do you wheeze or cough during or after exercise? Yes No

Do you have, or have you ever had asthma? Yes No

Do you have any questions or concerns that you would like to discuss? Yes No

Females:
At what age did you start your periods? ____

Have you had any problems with your periods? Yes No

If you do not understand any of these questions, please ask your nurse.