



TO BE COMPLETED BY THE PATIENT INDEPENDENTLY WHENEVER POSSIBLE

Today's Date: \_\_\_/\_\_\_/\_\_\_

Full Name of Patient: \_\_\_\_\_ (Nickname \_\_\_\_\_) Age: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

Previous or Ongoing Primary care physician(s) (if other than GTW): \_\_\_\_\_

Most recent "well-check" or annual physical: \_\_\_\_\_ Most recent baseline bloodwork (if applies) \_\_\_\_\_

Counselor/Psychiatrist(s) (if applies): \_\_\_\_\_

Specialists/other providers: \_\_\_\_\_

- IF NEW PATIENT Purpose of appointment is to O establish ongoing primary care O consult about a problem O both
How did you hear about us? O Physician O GTW patient O Friend O Speaking event
O Insurance O Internet O Other

- Most important concerns for this visit: Please explain (if applies)
O Annual physical exam (no concerns) School/Camp forms needed? O yes O no
O Physical symptoms
O Nutrition or body image
O Social/emotional/mood concerns
O Risk behaviors or safety
O Sexuality/Gynecology

REVIEW OF SYSTEMS: Do you have ONGOING OR RECURRENT CONCERNS about any of the following?

- O frequent allergy symptoms O abdominal pain O muscle/joint pain or swelling O excessive or unusual weight loss
O ear problems O frequent constipation O numbness or tingling O sleep problems
O eye problems O recurrent diarrhea O muscle weakness O persistent fatigue
O frequent or severe headaches O increased thirst O hair or nail problems O excessive worry (anxiety)
O frequent or recurrent cough O frequent or painful urination O acne O excessive sadness (depression)
O wheezing O bedwetting O rash/sores O thoughts of self-harm
O dizziness or passing out O abnormal vaginal discharge O frequent infections O recurrent thoughts of death
O chest pain with activity O worries about periods O night sweats O behavior problems
O swollen glands O other (explain):

First day of last period: \_\_\_/\_\_\_ Periods: O regular O irregular Cramping: O none- mild O moderate O severe

If no periods yet, approximate date (month and year) of breast bud changes (if applies) \_\_\_\_\_

STRENGTHS

What do you like the most about yourself (what are the best things about you)? \_\_\_\_\_

If you could change one thing about your life, what would it be? \_\_\_\_\_

SOCIAL HISTORY IF ESTABLISHED PATIENT, NOTE ANY NEW INFORMATION BELOW OR CHECK \_\_\_\_\_ NO CHANGES NOTED

Current school and grade: \_\_\_\_\_ and/or Highest grade level completed: \_\_\_\_\_ Current job: \_\_\_\_\_

Typical grades you usually get in school? O A's O B's O C's O D's O F's Comfortable with academic performance? O yes O no

List activities, clubs, hobbies, volunteer work, jobs, and religious activities: \_\_\_\_\_

With whom do you live most of the time? O Mother O Father O Step-parent(s) O Brother(s) O Sister(s) O Roommate O Other \_\_\_\_\_

Sister(s) ages: \_\_\_\_\_ Brother(s) ages: \_\_\_\_\_

If you live in more than one home, what are the custodial arrangements? \_\_\_\_\_

If applies: Mother's job: \_\_\_\_\_ ( \_\_\_ part-time \_\_\_ full-time) Step-Father's job: \_\_\_\_\_ ( \_\_\_ part-time \_\_\_ full-time)

Father's job: \_\_\_\_\_ ( \_\_\_ part-time \_\_\_ full-time) Step-Mother's job: \_\_\_\_\_ ( \_\_\_ part-time \_\_\_ full-time)

Stressors/Changes: O New school O Parental job loss O Death of friend or family O Parent separation/divorce O Family illness O Other \_\_\_\_\_

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**Allergies/Immunizations/Medications/Surgeries/Hospitalizations** (\_\_\_no changes since last visit, if applies)

**Allergies to Medications** type of reaction (e.g. penicillin, hives):  none  explain: \_\_\_\_\_

**Immunizations**  Up to date  Not sure (please make sure GTW has a copy of your past immunization records on file)

Medications, vitamins, supplements	Dose	How often	Prescribing Physician	Start Date / How Long?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Surgeries or Major Injuries	Date or Age	Hospitalizations	Date or Age
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Medical History (please note age of diagnosis)** (\_\_\_no changes since last visit, if applies)

Age	Age	Age	Age
___ <input type="radio"/> Acne	___ <input type="radio"/> Heart problems	___ <input type="radio"/> Scoliosis	___ <input type="radio"/> Anxiety or depression
___ <input type="radio"/> Eczema	___ <input type="radio"/> Abnormal heart rhythm	___ <input type="radio"/> Severe menstrual cramps	___ <input type="radio"/> Smoking/tobacco use
___ <input type="radio"/> Seasonal allergies	___ <input type="radio"/> Dizziness/fainting w/exercise	___ <input type="radio"/> Ovarian cysts	___ <input type="radio"/> Alcohol abuse
___ <input type="radio"/> Asthma	___ <input type="radio"/> Blood clots	___ <input type="radio"/> History of transfusion	___ <input type="radio"/> Drug abuse
___ <input type="radio"/> Mononucleosis	___ <input type="radio"/> High cholesterol	___ <input type="radio"/> ADD / ADHD	___ <input type="radio"/> Other(s)
___ <input type="radio"/> Migraine headache	___ <input type="radio"/> Food allergies	___ <input type="radio"/> Learning disability	___ <input type="radio"/> _____
___ <input type="radio"/> Seizures	___ <input type="radio"/> Chronic constipation	___ <input type="radio"/> Speech/language delay	___ <input type="radio"/> _____
___ <input type="radio"/> Diabetes	___ <input type="radio"/> Recurrent diarrhea	___ <input type="radio"/> Autism or Asperger's	___ <input type="radio"/> _____
___ <input type="radio"/> Thyroid problems	___ <input type="radio"/> Urinary tract infections	___ <input type="radio"/> Eating disorder	___ <input type="radio"/> _____
___ <input type="radio"/> Autoimmune diseases	___ <input type="radio"/> Broken bone(s): _____		

**Family History** (\_\_\_no changes since last visit, if applies)

(\_\_\_ Mark here if patient is adopted or family history unknown)

	Mother	Father	Siblings	Maternal Grandparents	Paternal Grandparents	Other Family (State Relationship)
Allergies	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> _____
Anxiety/Depression/Mental Illness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> _____
Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> _____
Attention deficit disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> _____
Bleeding or clotting disorders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> _____
Blood disorders or sickle cell anemia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> _____
Cancer (type) (_____)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> _____
Depression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> _____
Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> _____
Eating disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> _____
Excessive drinking or alcoholism	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> _____
Drug addiction	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> _____
High blood pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> _____
High cholesterol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> _____
Kidney disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> _____
Learning disability	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> _____
Migraine headaches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> _____
Obesity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> _____
Seizures or epilepsy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> _____
Stroke/Heart Attack (before 55 men, 60 women)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> _____
Sudden cardiac death (teen or young adult)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> _____
Suicide	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> _____
Thyroid disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> _____
Other: _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> _____

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**ANNUAL NUTRITION / PSYCHOSOCIAL / BEHAVIORAL SCREENING QUESTIONNAIRE**

TO BE COMPLETED BY THE **PATIENT** INDEPENDENTLY

**Activity, Nutrition, and Body Image**

- How many days per week do you participate in active physical play or exercise or sports?  None  1-2 days  3-4 days  5 or more days
- How many times *per week* do you eat breakfast?  None  1-2  3-4  5 or more
- How many milk/dairy/calcium servings do you have most days (including calcium supplements)?  None  1-2  3-4 or more
- How many servings of vegetables and fruit (combined) do you have most days?  None  1-2  3-5  6 or more
- How many times *per week* do you have sugared drinks (like sodas, sports drinks, or lemonade)?  None  1-2  3-4  5 or more
- How many times *per week* do you have caffeine (include energy drinks or caffeine pills/supplements)?  None  1-2  3-4  5 or more
- How often do you worry or feel bad about your weight, size, or body shape?  Rarely  Sometimes  Often
- What (if anything) have you done to try to change your weight?  
 Nothing  Eat more vegetables  Be more active  Limit servings or portion sizes  Decrease sodas/soft drinks  
 Strict diet  Get rid of calories (explain) \_\_\_\_\_  Other (explain) \_\_\_\_\_

If anyone else is worried about your weight or eating habits, please explain: \_\_\_\_\_

**Emotions, Support, and Stress Management**

- | <i>Do you have any concerns about:</i>                | <i>No</i>             | <i>Yes</i>            | <i>Not sure</i>       | <i>Please explain (if applies)</i> |
|---|-----------------------|-----------------------|-----------------------|------------------------------------|
| Relationships with family                             | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____                              |
| Relationships with friends/peers                      | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____                              |
| Feelings of depression (extreme sadness)              | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____                              |
| Feelings of anxiety (extreme worry)                   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____                              |
| Thoughts (or actions) of self-harm                    | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____                              |
| Abuse (emotional, physical, sexual)                   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____                              |
| Are your parents or friends worried about your moods? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____                              |
| What do you typically do to relieve your stress?      | _____                 |                       |                       |                                    |

**Safety and Risk Behaviors**

- |  | <i>No</i>             | <i>Yes</i>            | <i>Not sure</i>       | <i>Please explain (if applies)</i> |
|--|-----------------------|-----------------------|-----------------------|------------------------------------|
| Do you ever smoke cigarettes?  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____                              |
| Do you ever use alcohol, marijuana, or other drugs?                    | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____                              |
| Have you ever gotten in trouble for alcohol, marijuana or other drugs? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____                              |
| Do your parents worry about your behavior/decisions?                   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____                              |
| Are there any unlocked guns/firearms in your home?                     | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____                              |
| Do you worry about drug use or excessive drinking by family?           | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____                              |
| Do you worry about drug use or excessive drinking by friends?          | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____                              |

**Relationships and Sexuality**

- | <i>Do you have any questions or concerns about:</i> | <i>No</i>             | <i>Yes</i>            | <i>Not sure</i>       | <i>Please explain (if applies)</i> |
|---|-----------------------|-----------------------|-----------------------|------------------------------------|
| Being respected or safe in your relationships       | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____                              |
| Sexual orientation                                  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____                              |
| Contraception (birth control)                       | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____                              |
| Sexually transmitted infections                     | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | _____                              |

With whom are you most comfortable discussing relationships or sex?  mother  father  sibling  other \_\_\_\_\_

**PLEASE COMPLETE ONLY IF YOU HAVE STARTED HAVING PERIODS:**

- Have you ever had any kind of sexual contact (vaginal, oral, or anal sex)?  no  not sure  yes  
*If yes, who is aware?*  no one  mother  father  other \_\_\_\_\_
- Age at first intercourse: \_\_\_\_\_ Number of partner (in lifetime): \_\_\_\_\_ Condom use: \_\_\_\_\_% of the time
- Other contraceptive use:  Birth control pills  Patch  Nuvaring  Depo  Emergency contraception (Plan B)  Withdrawal  Other \_\_\_\_\_
- History of sexually transmitted infection?  no  yes  not sure History of pregnancy?  no  yes  not sure
- History of forced sexual contact or rape?  no  yes  not sure History of an abnormal Pap test?  no  yes  not sure