Metropolitan Pediatrics

Teen Health Screen (14+ Years)

Name: ______________________________ **Birthdate**: ______________ **Visit Date:**________________

General Health Updates

Who is completing this form?	☐ Patient ☐ Mom ☐ Dad ☐ Other, please list:
Any questions, concerns, or problems you want to discuss today?	
Any updates to your health? (i.e. new conditions, surgeries, etc.)	
Any family health, family status or social updates we should be aware of?	
Who lives with you?	
Any smoke or e-cigarette exposure?	
Anything else you want to share? (milestones, proud moments, etc.)	

Health Risk Screening

The following questions may prompt your provider to complete further testing, depending on the answer. Ask your provider if you have any questions about these health screening questions.

Have you seen an eye doctor in the last year?	☐ Yes ☐ No
Do you have any concerns about low iron levels or anemia?	☐ Yes ☐ No

Nutrition

How often do you drink caffeine, soda or other sugary/energy drinks?	☐ Daily ☐ Weekly ☐ Rarely ☐ Never
Do you have any concerns about your weight?	☐ Yes ☐ No
Do you eat three regular meals every day?	☐ Always ☐ Sometimes ☐ Never

Oral Health

Do you have any current dental decay/cavities?	☐ Yes ☐ No ☐ Unknown
Do you brush your teeth twice a day?	☐ Yes ☐ No
Have you been to a dentist in the last 6 months?	☐ Yes ☐ No

Sleep

Healthy sleep is important for growth, development, and learning. We do not recommend having a screen in your bedroom as this can affect sleep.

Question	Response
Do you have any concerns about the amount or quality of your sleep?	☐ Yes ☐ No
Do you get at least 8-10 hours of sleep a night?	☐ Yes ☐ No

Activity & Screen Time

Question	Response
Are you vigorously active for at least one hour a day?	☐ Yes ☐ No
Do you spend more than two hours a day in front of a screen that is not related to schoolwork?	☐ Yes ☐ No

School

Learning and socialization are a critical part of development and the skills learned there will continue to be used throughout life. Talk to your provider if you have any specific concerns, make sure to mention if you are on an IEP or have a 504 for extra support.

Question	Response
What grade are you in and what school do you attend?	
Do you enjoy school?	☐ Yes ☐ No
Do you have any current concerns or difficulties at school (such as failing classes, bullying, etc.) that you would like to talk about?	☐ Yes ☐ No
What are your plans after high school (such as college, trade program, work, etc)?	

Safety

Question	Response
Do you always wear a safety belt while riding or driving in a vehicle?	☐ Yes ☐ No
Do you use sunscreen regularly?	☐ Yes ☐ No
Do you have questions about water safety?	☐ Yes ☐ No
Do you wear a helmet every time you ride a bike, scooter, skateboard, ski/snowboard?	☐ Yes ☐ No
If you have guns in your home, are they stored safely (locked with ammunition stored separately)?	☐ Yes ☐ No ☐ Don’t have guns
Do you know how to be safe when using social media/internet?	☐ Yes ☐ No