If you have NOT completed an online Health Profile in the past 6 months, please answer the following questions. Kaiser Permanente values your privacy and will keep your answers confidential. If you don’t want to answer a question, feel free to leave it blank.

### Full name: [ ] Preferred name:

#### What is your gender?
- Female
- Male
- Transfemale
- Transmale
- Non-binary or other
- Choose not to answer

#### Pronouns:
- Staff:
  - In note, use .genderhealth

Who are the people that live with you? (include names, ages, relationships):

Are you in school?
- Yes
- No
- If YES, what year are you in school? ____________________
- Where do you go to school? _________________________
- If you’re in school, are you having a hard time?
  - Yes
  - No

Do you have a job?
- Yes
- No
- If YES, what do you do? ______________________________
- In this job, do you work more than 20 hours a week?
  - Yes
  - No

What sports, activities, and hobbies are you involved in?

On average, how many days per week do you do moderate to strenuous exercise, like a brisk walk or jog?
- 0
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- Don’t know

On average, how many minutes do you exercise at this level each day? ______________

Have you ever:
- Passed out while exercising?
  - Yes
  - No
- Gotten dizzy or had headaches while exercising?
  - Yes
  - No
- Been knocked out?
  - Yes
  - No
- Had a significant joint or bone problem?
  - Yes
  - No
- Had a serious injury?
  - Yes
  - No
- Can you run twice around a ¼ mile track without stopping?
  - Yes
  - No

Do you eat fruits and vegetables every day?
- Yes
- No

Do you eat or drink dairy products?
- Yes
- No

Are you a vegetarian?
- Yes
- No

Do you have any questions or concerns about your eating habits?
- Yes
- No

If you ride a motorcycle or bicycle, do you always use a helmet?
- Yes
- No
- Doesn’t apply to me

Do you always use your seat belt when in a car?
- Yes
- No
- Doesn’t apply to me

Do you ever text while driving?
- Yes
- No
- Doesn’t apply to me

Do you ever drive under the influence of alcohol or drugs, or ride with a driver who is?
- Yes
- No

Do you have access to guns?
- Yes
- No

If yes, are they stored unloaded and locked?
- Yes
- No
- Don’t know

---

DO NOT SCAN IN MEDICAL RECORD
Enter information in note using dot phrase .wq18to21, then destroy paper form.
### Well-Care Questionnaire
for young adults aged 18 to 21

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you get along with your family?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you having a hard time with the people you live with?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have a friend you can talk to about any problems you have?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you having a hard time with friends including your boyfriend or girlfriend?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you having trouble with fighting or bullying?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you feeling pressure to do what others are doing?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever been a victim of threats, physical hurting, or forced sexual contact?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>During the past 2 years, have you, or has anyone in your family, had any major good or bad changes?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Do you have any concerns about your body or weight?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Do you ever eat in secret or feel guilty about eating?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Do you ever make yourself throw up?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Have you ever used tobacco or nicotine products (cigarettes, chew, e-cigarettes, vaping device)?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Are you attracted to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>Women</td>
<td>Both</td>
</tr>
<tr>
<td>Have you ever had sex?</td>
<td>Yes</td>
<td>No - skip to next section</td>
</tr>
<tr>
<td>Have your sexual partners included:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>Women</td>
<td>Transmen</td>
</tr>
<tr>
<td>Did you use condoms or other barrier during sex?</td>
<td>Always</td>
<td>Sometimes</td>
</tr>
<tr>
<td>How many sexual partners have you had in the last 3 months?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you been tested for HIV?</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Are any of your current sexual partners known to be HIV positive?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>When you have sex, how often do you, or does your partner, use protection from pregnancy other than a condom?</td>
<td>Always</td>
<td>Sometimes</td>
</tr>
<tr>
<td>Doesn’t apply to me</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you or your partner use protection, what kind:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condoms</td>
<td>Birth control pills</td>
<td>IUD</td>
</tr>
<tr>
<td>Many sexually transmitted infections (STI) do not have symptoms you can see or feel. That’s why it’s important to get tested if you could be at risk. Places that could be infected by an STI include the genitals, anus, throat, and mouth. When we screen for STIs, we routinely test all sites that could be infected. Are there any sites you don’t want me to check?</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Menstrual, Pregnancy History</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How old were you when your periods started?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are your periods regular?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Doesn’t apply to me</td>
<td></td>
<td></td>
</tr>
<tr>
<td>When was your most recent period?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doesn’t apply to me</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do menstrual cramps keep you from doing normal activities?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Doesn’t apply to me</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>On birth control that prevents periods</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Taking gender affirming hormones that prevent periods</td>
<td>None of these</td>
<td></td>
</tr>
<tr>
<td>Are you pregnant or planning to get pregnant within the next year?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If YES, are you taking a daily supplement that has folate (folic acid)?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Have you ever been pregnant?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If you have been pregnant:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Number of full-term pregnancies: ____ Number of miscarriages or abortions:____
## Medical and Surgical History

Please list any major illnesses, injuries, or conditions that were treated outside Kaiser Permanente that you haven’t told us about in the past.

- None

Please list any major surgeries performed outside Kaiser Permanente that you haven’t told us about in the past. List each one and the approximate year.

- None

## Personal and Family History (those related to you by blood)

Do you have a personal or family history of breast cancer?  
- Yes  
- No  
- Don’t know

If YES, please describe (ie: you, which family member):

- If YES, give Breast Cancer Risk Questionnaire and complete Epic flowsheet (BCRQ).

Did any of the following family members develop heart disease? Check all that apply.

- Before age 55: father, brother, or son
  - None before age 55
  - Don’t know

- Before age 60: mother, sister, or daughter
  - None before age 60
  - Don’t know

Have you ever had Crohn’s disease, ulcerative colitis, colon polyps, or colon cancer?  
- Yes  
- No

- If YES: Consult GI.

Have you had a mother, father, sister, brother, daughter, or son diagnosed with the following?

- Colon cancer:  
  - No  
  - Yes – at what age:_____
  - Don’t know

- Colon polyps:  
  - No  
  - Yes – at what age:_____
  - Don’t know

Have you had a grandparent, aunt, uncle, niece, or nephew diagnosed with the following?

- Colon cancer:  
  - No  
  - Yes – at what age:_____
  - Don’t know

If YES to either question above, please circle the relative(s) with the condition.

## Advanced Care Planning

Do you have a signed Living Will?  
- Yes  
- No  
- Don’t know

Do you have an up-to-date Durable Power of Attorney for health care?  
- Yes  
- No  
- Don’t know

- If documents are presented, send for scanning to Advance Directives Registry.