KAISER PERMANENTE®

Well-Care Questionnaire
for young adults aged 18 to 21

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):	**Flow Staff:** Enter using dot phrase .wq18to21
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**	

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DO NOT SCAN IN MEDICAL RECORD
Enter information in note using dot phrase .wq18to21, then destroy paper form.

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Do you get along with your family? ☐ Yes ☐ **No** Are you having a hard time with the people you live with? ☐ **Yes** ☐ No Do you have a friend you can talk to about any problems you have? ☐ Yes ☐ **No** Are you having a hard time with friends including your boyfriend or girlfriend? ☐ **Yes** ☐ No Are you having trouble with fighting or bullying? ☐ **Yes** ☐ No Are you feeling pressure to do what others are doing? ☐ **Yes** ☐ No Have you ever been a victim of threats, physical hurting, or forced sexual contact? ☐ **Yes** ☐ No	
During the past 2 years, have you, or has anyone in your family, had any major good or bad changes? ☐ **Yes** ☐ No If YES, please explain: Do you have any concerns about your body or weight? ☐ **Yes** ☐ No Do you ever eat in secret or feel guilty about eating? ☐ **Yes** ☐ No Do you ever make yourself throw up? ☐ **Yes** ☐ No	
Have you ever used tobacco or nicotine products (cigarettes, chew, e-cigarettes, vaping device)? ☐ **Yes** ☐ No	If YES: Complete Tobacco History section in Epic
Are you attracted to: ☐ Men ☐ Women ☐ Both ☐Non binary people ☐ No one Have you ever had sex? ☐ **Yes** ☐ No – skip to next section Have your sexual partners included: ☐ Men ☐ Women ☐ Transmen ☐Transwomen ☐Non-binary people Did you use condoms or other barrier during sex? ☐ Always ☐ **Sometimes** ☐ **Never** How many sexual partners have you had in the last 3 months? _____ Have you been tested for HIV? ☐ No ☐ Yes Are any of your current sexual partners known to be HIV positive: ☐ **Yes** ☐ No When you have sex, how often do you, or does your partner, use protection from pregnancy other than a condom? ☐ Always ☐ **Sometimes** ☐ **Never** ☐ Doesn't apply to me If you or your partner use protection, what kind: ☐ Condoms ☐ Birth control pills ☐ IUD ☐ Depo-Provera ☐Other:_____ 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? ☐ No ☐ Yes	If YES to "ever had sex", give handout on Routine HIV Testing
Menstrual, Pregnancy History	
How old where you when your periods started? _____ Are your periods regular? ☐ Yes ☐ **No** ☐ Doesn't apply to me When was your most recent period? _____ ☐ Doesn't apply to me Do menstrual cramps keep you from doing normal activities? ☐ **Yes** ☐ No ☐Doesn't apply to me Are you: ☐ On birth control that prevents periods ☐ Taking gender affirming hormones that prevent periods ☐ None of these Are you pregnant or planning to get pregnant within the next year? ☐ **Yes** ☐ No If YES, are you taking a daily supplement that has folate (folic acid)? ☐ Yes ☐ **No** Have you ever been pregnant? ☐ **Yes** ☐ No If you **have** been pregnant: Number of full-term pregnancies: ____ Number of miscarriages or abortions:____	If **yes** to pregnant: Enter in OB History section of Epic.

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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	**Provider or RN** Enter major illnesses, injuries, or conditions into PMH section or Problem List in Epic as appropriate. Enter major surgeries into PSH section in Epic.
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.	If YES to family history: See Colorectal Cancer Screening Guideline for screening recommendations.
Do you have a personal or family history of ovarian 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).

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.