

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.

Name: _____

Who are the people that live with you? (include names, ages, relationships):	Flow Staff: Enter using dot phrase .wq18to21
Are you in school? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have a job? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, what do you do? _____ In this job, do you work more than 20 hours a week? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> Don't know On average, how many minutes do you exercise at this level each day? _____	
Have you ever: Passed out while exercising? <input type="checkbox"/> Yes <input type="checkbox"/> No Gotten dizzy or had headaches while exercising? <input type="checkbox"/> Yes <input type="checkbox"/> No Been knocked out? <input type="checkbox"/> Yes <input type="checkbox"/> No Had a significant joint or bone problem? <input type="checkbox"/> Yes <input type="checkbox"/> No Had a serious injury? <input type="checkbox"/> Yes <input type="checkbox"/> No Can you run twice around a ¼ mile track without stopping? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you eat fruits and vegetables every day? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you eat or drink dairy products? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you a vegetarian? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any questions or concerns about your eating habits? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If you ride a motorcycle or bicycle, do you always use a helmet? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't apply to me Do you always use your seat belt when in a car? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't apply to me Do you text while driving? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't apply to me Do you ever drive under the influence of alcohol or drugs, or ride with a driver who is? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you or any of your friends have access to guns? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, are they stored unloaded and locked? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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.

Do you get along with your family? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you having a hard time with the people you live with? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have a friend you can talk to about any problems you have? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you having a hard time with friends including your boyfriend or girlfriend? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you having trouble with fighting or bullying? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you feeling pressure to do what others are doing? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever been a victim of threats, physical hurting, or forced sexual contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	
During the past 2 years, have you, or has anyone in your family, had any major good or bad changes? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please explain: Do you have any concerns about your body or weight? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you ever eat in secret or feel guilty about eating? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you ever make yourself throw up? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever used tobacco (smoke, chew, or e-cigarettes) or vapor product? <input type="checkbox"/> Yes <input type="checkbox"/> No	If YES: Complete Tobacco History section in Epic
Are you attracted to: <input type="checkbox"/> Males <input type="checkbox"/> Females <input type="checkbox"/> Both <input type="checkbox"/> Not sure Have you ever had sex? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, are, or were, your sexual partners: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Both Are any of your current sexual partners known to be HIV positive: <input type="checkbox"/> Yes <input type="checkbox"/> No Have you had sex with a new partner(s) in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, did you use condoms? <input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Never When you have sex, how often do you, or does your partner, use protection from pregnancy other than a condom? <input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Never <input type="checkbox"/> Doesn't apply to me If you use - or your partner uses - protection, what kind do you or your partner use (please list): <input type="checkbox"/> Condoms <input type="checkbox"/> Birth control pills <input type="checkbox"/> IUD <input type="checkbox"/> Depo-Provera <input type="checkbox"/> Other: _____ Have you ever been pregnant or made someone pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	If YES to "ever had sex", give handout on Routine HIV Testing
For Women	
How old were you when your periods started? _____ Are your periods regular? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't apply to me When was your most recent period? _____ <input type="checkbox"/> Doesn't apply to me Do menstrual cramps keep you from doing your normal activities? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't apply to me 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.
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. <input type="checkbox"/> None	Provider or RN Enter major illnesses, injuries, or conditions into PMH section or Problem List in Epic as appropriate.
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. <input type="checkbox"/> None	Enter major surgeries into PSH section in Epic.

Personal and Family History (those related to you by blood)	
Do you have a personal or family history of breast cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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. <input type="checkbox"/> Before age 55: father, brother, or son <input type="checkbox"/> None before age 55 <input type="checkbox"/> Don't know <input type="checkbox"/> Before age 60: mother, sister, or daughter <input type="checkbox"/> None before age 60 <input type="checkbox"/> Don't know	
Have you ever had Crohn's disease, ulcerative colitis, colon polyps, or colon cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No	If YES: Consult GI.
Have you had a mother, father, sister, brother, daughter, or son diagnosed with the following? Colon cancer: <input type="checkbox"/> No <input type="checkbox"/> Yes - at what age:____ <input type="checkbox"/> Don't know Colon polyps: <input type="checkbox"/> No <input type="checkbox"/> Yes - at what age:____ <input type="checkbox"/> Don't know Have you had a grandparent, aunt, uncle, niece, or nephew diagnosed with the following? Colon cancer: <input type="checkbox"/> No <input type="checkbox"/> Yes - at what age:____ <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know If YES, please describe (ie you, which family member):	If YES, give Breast Cancer Risk Questionnaire and complete Epic flowsheet (BCRQ).