Teen Questionnaire for Teen Health Care Visit

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Your Name: ____________________

Please answer the following questions. Your answers are confidential between you and your clinician, and are not shared with anyone without your consent. If you are uncomfortable with any question, leave it blank. PLEASE COMPLETE BOTH SIDES.

Please list all medications, vitamins, inhalers or supplements that you are currently taking: ____________________

____

Please list your medication or food allergies, if any: ____________________

____

Have you had any major medical problems since your last checkup? No Yes
If yes, please list ____________________

Do you have any injuries that still bother you? No Yes

Parents are: ☐ Married ☐ Unmarried ☐ Separated/ Divorced ☐ Other ____________________

SCHOOL
Current Grade/name of school ____________________
Do you have any *concerns about your performance* in school? No Yes Unsure
Do your *parents or teachers have concerns* about your school performance? No Yes Unsure
What are your plans after high school? ____________________

NUTRITION
How much *juice, soda, or sports drink* do you drink everyday? ______ oz
Are you *unhappy with your weight?* No Yes
Have you ever *skipped meals, taken pills, or made yourself vomit to lose weight?* No Yes
Are you a *vegetarian?* No Yes
Do you get at least 4 servings of milk or other calcium-containing foods daily? Yes No

PHYSICAL ACTIVITY/EXERCISE RISK FACTORS
Aside from homework, how many hours a day are you *using a TV, computer or your cell phone?* ☐ 0-2 hours ☐ 2-4 hours ☐ 4+

Do you play on a school or club team? Yes No
If yes, what sport(s)? ____________________

Have you ever fainted while exercising? No Yes
Do you typically *cough or have shortness of breath when you exercise?* No Yes
Have you gotten *aching chest pain* when you exercise? No Yes
Have you had a *head injury* in the last two years that affected sports or school? No Yes
Did anyone in your family *die suddenly while exercising?* No Yes Unsure
Has anyone in your family had a *heart attack or stroke before age 55?* No Yes Unsure
Do you get *at least one hour* of moderately strenuous activity daily? Yes No

SLEEP
Do you drink *coffee, energy drinks, or caffeinated drinks?* No Yes
If yes, what kind and how many a day? ____________________
How many hours per night do you usually sleep? ☐ 9+ ☐ 7 - 9 ☐ fewer than 7

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SAFETY			
Do you wear *sunscreen/hats/other sun protection measures* when outdoors?	Yes	No	Unsure
Do you wear a *seatbelt* when riding in a car, truck or van?	Yes	No	Unsure
Do you wear a *helmet* when skateboarding, rollerblading, or riding a bicycle or scooter?	Yes	No	Unsure
Does your home have *smoke detectors*?	Yes	No	Unsure
Do students in your school *carry guns or knives* to school?	No	Yes	Unsure
Are you worried about *bullying, violence,* or your safety at school?	No	Yes	Unsure
Have you or your friends ever been in *trouble with the police*?	No	Yes	Unsure
Is there a *gun* in your home?	No	Yes	Unsure

SOCIAL HISTORY			
Do you live at *more than one home*?	No	Yes	
Who lives with you? Please list (parents, sister, uncle and so on): ____________________			
Do you have concerns about how your *family gets along*?	No	Yes	Unsure
Are you *worried about violence* or your safety at home?	No	Yes	Unsure

SUBSTANCE USE		
Do you smoke *cigarettes or chew tobacco*?	No	Yes
Does anyone in your *home smoke cigarettes*?	No	Yes
Do you drink *alcohol*?	No	Yes
Have you ever been *drunk*?	No	Yes
Have you ever used *drugs* such as marijuana, ecstasy, meth, or others?	No	Yes
Do any of your *friends smoke cigarettes or chew tobacco,* drink alcohol, or use drugs?	No	Yes
Have you ever driven or been in a car with a *driver under the influence of drugs or alcohol*?	No	Yes

MENTAL HEALTH			
In the past few weeks have you been *depressed or extremely sad*?	No	Yes	Unsure
Have you ever had *thoughts about harming yourself* or committing suicide?	No	Yes	Unsure
Have you ever been *abused* physically, emotionally or sexually?	No	Yes	Unsure
Do you need help managing your stress?	No	Yes	

SEXUAL HEALTH			
Have you ever had *sexual intercourse*?	No	Yes	Unsure
Do you need information about *preventing pregnancy* or sexually transmitted infections?	No	Yes	Unsure
Do you need information about *bisexuality or being gay* (homosexual)?	No	Yes	Unsure
Would you like a *pregnancy test or sexually transmitted infection testing*?	No	Yes	Unsure

FOR GIRLS ONLY		
Have you *started* your period?	Yes	No
Do you need *help managing problems with your period*?	No	Yes

Any other concerns that you would like to discuss today? If so, please list them: ____________________

____

____

Print Name

____

Signature

____

Date