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ADOLESCENT HEALTH HISTORY QUESTIONNAIRE (ages 13-17)

Please answer these questions privately. Give this form to your health care provider, who will be willing to discuss it with you. This information will not be shared with your parents unless we have your permission.

Age_____ Grade in school _____ Today's date _____

Who lives in your household? _____

Are you attending school? _____ What grades do you usually receive? _____

What are your future school or job plans? _____

Do you take any medicines (including birth control pills, diet pills, laxatives, steroids, vitamins)? _____

If yes, what are they? _____

Females Only- Start date of last menstrual cycle_____ Any issues/concerns w/ your period?_____

_____

Have you been feeling sad about anything? . . . . . yes _____ no _____

Have alcohol or drugs caused a problem for you or someone you know? . . . . . yes _____ no _____

Have you used alcohol or drugs? . . . . . yes _____ no _____

How many times a week? _____

Do you use tobacco products (smoking, chewing)? . . . . . yes _____ no _____

Have you ever ridden in a car driven by someone (including yourself) who was "high" or drunk? _____

Have you considered suicide? . . . . . yes _____ no _____

Have you or anyone in your family been abused/raped/assaulted? . . . . . yes _____ no _____

Are you or any of your friends in a gang? . . . . . yes _____ no _____

Do you ever wonder about being gay? . . . . . yes _____ no _____

Have you ever had sexual relationships (gone all the way) with anyone? . . . . . yes _____ no _____

Do you want more information about birth control? . . . . . yes _____ no _____

Do you have any questions about AIDS or other STDs such as gonorrhea or chlamydia? Please specify:

_____

Are you having problems at home, school, or with friends? . . . . . yes _____ no _____

Are you pleased with your height and weight? . . . . . yes _____ no _____

Has anyone ever touched you in a way that felt uncomfortable to you? . . . . . yes _____ no _____

What do you consider to be methods of safe sex? _____

_____

Are there any guns in your home? . . . . . yes _____ no _____

Are you involved in sports? . . . . . yes _____ no _____

Is there anything else you would like to discuss during your visit? Please specify: _____

_____

May we share this information with your parents? . . . . . yes _____ no _____

_____ _____

Signature Date