ADOLESCENT PATIENT QUESTIONNAIRE

PCP _____ **ALLERGIES** _____

NAME _____ DOB _____ MR#_____

GENERAL INFORMATION **Date:** _____

1. Full Name _____ Preferred Name_____

2. Is this Office the main place you go for health care? ☐ Yes ☐ No

3. What other places do you go for health care or counseling? It may be necessary to check records at other places to find out about illnesses you have had, medicines prescribed, or tests that have been done in the past. *We will not get this information unless you sign a permission slip.* Private doctor or clinic_____

4. When did you last have (approximately): A dental exam? _____ An eye exam? _____ A physical exam? _____

PRESENT HEALTH CONCERNS

5. On a scale of one to ten, how would you rate your general health? 1 2 3 4 5 6 7 8 9 10
awful great

6. Please check any of the following common concerns which apply to you:

☐ stomachaches	☐ skin problems	☐ feeling down or depressed	☐ leg pains
☐ waking up at night	☐ tired during the day	☐ trouble with school or teachers	☐ parents
☐ wetting the bed	☐ my height or weight	☐ problems with menstrual periods	☐ a place to live
☐ headaches	☐ sex or pregnancy	☐ trouble falling asleep	☐ dizzy spells

7. Is there anything about your health that worries you? ☐ no ☐ yes _____

8. What prescription medicines or birth control pills do you take? ☐ none _____

9. What about using any other drugs—either street drugs or nonprescription drugs? Check those that apply (all information is confidential):

☐ Sleeping pills	☐ No Doz	☐ Marijuana	☐ Heroin	☐ Alcohol	
☐ Aspirin	☐ Water pills	☐ Pain pills	☐ Speed	☐ Cold pills	☐ Inhaled chemicals
☐ Laxatives	☐ Midol	☐ Diet pills	☐ Methadone	☐ Cigarettes	☐ Other (specify) _____

10. List all medications, animals, plants, and foods to which you are allergic and the type of reaction you have had.
_____ ☐ None

11. Sex is often an important part of people's lives. Though it's very private and sometimes embarrassing, we hope you will share some information with us so we can better help meet your personal needs, concerns and questions. This information is strictly confidential. If you are having sex, what kind(s) of birth control methods do you and your partner now use?

☐ diaphragm	☐ foam	☐ Depo-Provera	
☐ not having sex	☐ condoms (rubbers)	☐ withdrawal	☐ None
☐ I.U.D. (intrauterine device)	☐ rhythm	☐ pill	☐ other (explain)_____

12. Have you used other birth control methods in the past? ☐ No ☐ Yes
If yes, what method, and why did you stop using it? _____

13. Have you ever had a sexually transmitted disease (herpes, genital warts, gonorrhea, chlamydia)? ☐ No ☐ Yes

14. Have you ever been sexually mistreated by a member of your family? ☐ No ☐ Yes By someone else? ☐ No ☐ Yes

PAST HEALTH HISTORY

15. Have you ever:
   a. Stayed overnight in the hospital? ☐ No ☐ Yes For what _____ When? _____
   b. Had an operation or abortion? ☐ No ☐ Yes What kind? _____ When? _____
   c. Had any serious injuries (concussions, broken bones, etc.)? ☐ No ☐ Yes
   What kind? _____ When? _____

16. As you were growing up, you probably had some childhood diseases or possibly other problems. Please check those that you remember having had (or now have).

☐ measles	☐ diabetes	☐ heart problems ☐ cancer	
☐ mumps	☐ vaginal or pelvic infections	☐ high blood pressure	☐ headaches
☐ chicken pox	☐ trouble seeing or hearing	☐ seizures	☐ dizzy spells
☐ German measles	☐ breathing problems/asthma	☐ stomach problems	☐ Other _____
☐ rheumatic fever	☐ bladder or kidney problems	☐ hepatitis	

FAMILY HEALTH

17. Has anyone in your family ever had:

☐ Seizures	☐ Glaucoma	☐ Thyroid Disease	☐ Osteoporosis
☐ Arthritis	☐ Diabetes	☐ Migraine	☐ Alcoholism
☐ Allergies	☐ Breast Cancer	☐ Asthma	☐ Cervical Cancer
☐ Heart Disease	☐ Prostate Cancer	☐ Stroke	☐ Lung Cancer
☐ High Blood Pressure	☐ Intestinal Cancer	☐ Tuberculosis	☐ Mental/Emotional Illness
☐ Any other (please list)			

18. Are both your mother and father alive? ☐ Yes ☐ No If no, please explain:_____

19. How many brothers and sisters do you have and what are their ages?
Brothers _____ Sisters _____

20. Who lives at home with you? (brothers, sisters, parents, grandparents, etc.): _____

21. Do you feel you are physically mistreated (hit or beaten) by a member of your family? ☐ Yes ☐ No

FOR WOMEN ONLY

22. Have you started having menstrual periods? ☐ No ☐ Yes

If yes: How old were you when you had your first period? _____years

About how many days between periods? _____ days. How long does your period usually last? _____ days.

Do you ever miss periods? ☐ No ☐ Yes Date of your last period: _____

23. Have you ever been pregnant? ☐ No ☐ Yes If yes, how many times? _____

_____ _____

Date Reviewed PCP Signature