Selah Family Medicine
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Adolescent Questionnaire

This questionnaire will become a completely CONFIDENTIAL and PRIVATE part of your medical record except in those cases where we are required by law to release certain information concerning a history of abuse or threats of harm to yourself or others. (If you have questions about this, please ask) Please fill out the entire form. If you do not want to answer a question leave it blank.

NAME_____Today's Date_____
Best way for us to contact you_____Home Phone_____
Emergency Contact: Name_____Phone number_____
Relationship to you_____

HOUSING: Where do you sleep _____house/apt _____shelter ____other
Who lives with you?_____

SCHOOL: Do you go to school? _____yes _____no If yes, where_____
What grade_____Are you having problems in school?_____yes _____no
If yes, what are they?_____
What activities, other than classes do you participate in?_____

SAFETY:
Do you have or own a gun? _____yes _____no Are there guns in your house? _____yes _____no
Do you feel safe at home? _____yes _____no Do you feel safe at school? _____yes _____no

EMOTIONS: Do you feel sad or blue most of the time? _____yes _____no
Do you feel hopeless about the future? _____yes _____no
Who do you talk to when you have a problem? _____
Have you thought about killing yourself? _____yes _____no Have you tried to kill yourself? _____yes _____no

WEIGHT: Are you happy with our current weight? _____yes _____no
Are you trying to lose weight? _____yes _____no Trying to gain weight? ____yes ____no

FAMILY HEALTH HISTORY:
Mother's age ____now ____when died Number of brothers_____
Father's age ____now ____when died Number of sisters_____
Are you adopted? _____yes _____no
For each illness below, please tell us if a parent or sibling (brother or sister) has had the illness

	Parent	Sibling		Parent	Sibling
Alcohol problems	_____	_____	Drug problems	_____	_____
Cancer	_____	_____	Heart attack before 60	_____	_____
List type_____			High blood pressure	_____	_____
Depression	_____	_____	Sickle Cell Anemia _____		_____
High Cholesterol	_____	_____	Tuberculosis	_____	_____
Diabetes _____		_____	Other Illnesses or conditions (explain) _____		

_____

PERSONAL HEALTH HISTORY:
What year was your last tetanus shot? _____ Have you had the Hepatitis B vaccine? ____ yes____ no ___not sure
Have you ever had any of the following? (Please check all that apply)

_____Arthritis	_____Broken bone	_____Genital warts	_____Depression
_____Heart disease	_____Chlamydia	_____Learning disability	_____Thyroid condition
_____Knee or ankle injury	_____Seizure(epilepsy)	_____Diabetes	_____Herpes
_____Positive TB test	_____Hepatitis	_____Gonorrhea	_____Blood transfusion

_____Other major illnesses, operations, injuries or conditions (describe and give year) _____

TOBACCO, ALCOHOL, AND OTHER DRUGS:

Have you ever smoked a cigarette, even a puff? ____yes _____no

If yes, do you smoke? _____every day _____every week_____less than once a month

Have you ever used chewing tobacco or snuff? ____yes _____no

Have you used marijuana? ____yes _____no Do you drink alcohol? ____yes _____no

If yes, how many drinks per week? (1 drink=1 glass wine, beer or hard liquor drink)

____1-5 ____6-8 ____9-13 _____14-17 _____18-21 _____22+

Do you ever ride or drive when the drive rhas had alcohol or drugs?_____yes _____no

Have you used or do have questions about:

_____LSD, mushrooms or PCP _____Speed (amphetamines) _____Cocaine, crack or ice

_____Heroin _____Inhalants (glue, paint, spray cans) _____Uppers (stimulants)

_____"Shooting up" or taking drugs by injection, including steroids _____Downers (sedatives, tranquilizers painkillers) _____Other drugs _____

SEXUALITY:

Do you have any questions about sex you would like to discuss today? ____yes _____no

Have you ever had sex? _____yes _____no Have you decided not to have sex until you are older? ____yes ____no

IF YOU EVER HAD SEX, please answer the following questions:

Are or were your sexual partners: _____male _____female _____both

What types of sex have you had? _____vaginal _____oral_____anal_____I'm not sure what these words mean

How often do you use birth control when you have sex? _____always _____sometimes _____never

What kind of birth control do you use?_____

How often do you use condoms during sex? _____always _____sometimes _____never

Do you ever have sex or feel pressured to have sex after drinking alcohol or using drugs? _____yes _____no

Have you ever exchanged sex for food, shelter or money? _____yes _____no

Have you ever had sex against your wishes or experienced unwanted sexual contact? _____yes _____no

Have you ever been raped? _____yes _____no

FOR WOMEN (Men skip to next section)

Have you had a menstrual period? _____yes _____no Age at time of first period_____ Date of last period _____

Have you ever been pregnant? ____yes ___no If yes, list number of: deliveries____miscarriages____abortions_____

Have you ever had a PAP smear or pelvic exam? ____yes ____no Date of last exam_____

CONCERNS: Check the items that you want to talk about:

_____Sexual development _____Eating habits or weight control _____Being gay or lesbian

_____Not getting along with parents _____Being pressured to conform _____Staying out of fights

_____Thoughts of ending your life/suicide_____You or someone you know were raped or sexually assaulted

_____Being in a relationship in which you were criticized frequently, threatened or physically hurt

_____Other

SPORTS PARTICIPATION SCREEN: Have you ever

Passed out or gotten dizzy while exercising? ___yes ___no

Had breathing problems while exercising? ___yes ___no

Been knocked out/unconscious? ___yes ___no

Had joint or bone problems? ___yes ___no

Had a significant injury? ___yes ___no