UniversityHospitalsHealthSystem Primary Care Physician Practices

NAME:	 Date of Birth:

TEEN HISTORY QUESTIONAIRE

IT IS THE POLICY IN OUR MEDICAL PRACTICE THAT ALL INFORMATION TEENAGERS SHARE WITH OUR HEALTH CARE PROVIDERS IS CONFIDENTIAL, UNLESS THAT INFORMATION ENDANGERS THE LIFE OF THE TEEN OR SOMEONE ELSE. HOWEVER, WE ENCOURAGE YOU TO DISCUSS THESE HEALTH MATTERS WITH YOUR PARENTS.

CIRCLE ANY of the following that concern you or that you have questions about:

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Acne Death Depression		Depression	Sexually transmitted	diseases		
AIDS	Sports	Masturbation	Alcohol	Fear		
Birth Control	Sex questions	Allergies	Homosexuality	Physical fitness		
Father problems		Eating	Headaches	Mother problems		
Weight Growth	Nutrition Breast changes	Sexual abuse Brother problems	Sister problems Virginity	Body odor Appearance		
	Penis discharge		Matriage	Family problems		
Seeing visions	Worries	Cigarettes	Bed wetting	Physical abuse		
Suicide	Drugs	School/grades	•	•		
YOUR AGE_						
Do you smo	oke cigare	ttes?	***************************************	YES		
If you smo	oke cigaret	ttes, how many	packs a day?	?		
Do you use	e street di	rugs?		YES		
If yes, wh	nat					
Do you dr	ink alcoho	1.?		NOYES		
If yes, he	ow much and	d what kind?				
Does it by	urn when yo	ou urinate (pa	ss your water)	?YES		
If yes, how much and what kind? Does it burn when you urinate (pass your water)?NOYES Do you wet the bed?NOYES						
Have you had a sexually transmitted disease(STD/VD)?NOYES						
Do you think you have a sexually transmit; ed disease						
now?	*********	*******************************		NOYES		
Do you have problems with acne?						
Have you ever repeated a grade?						
Do you miss more than three days of school a month?.NOYES What kind of grades did you get on your last report						
What kind	of grades	did you get o	n your last re	eport		
card?			······································			
What do yo	ou want to	do when you g	raduate?	NO YES		
Card? What do you want to do when you graduate? Do you have any friends?						
Do you wish you were dead?NOYES Do you have sex with your girlfriend or boyfriend?NOYES						
Do you ha	ve sex wit.	n your giriiri	. nrognancy £/	511Q1,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
			pregnancy &/c			
diseases?		-la ant magne	nt?	YESNO		
Do you kn	ow now beo	bie der bredue	th each other	?YESNO		
Do your parents get along well with each other?YESNO Do you get along with your mother?YESNO						
Do you ge	r arond wr	ch your mother	()	over) →		
			`			

Do you get along with your for Is there anything you would without your parents being he What did you eat yesterday?	like to ask or	talk about
Breakfast: Lunch:	<u>Dinner</u> :	In-between:
Patient's signature		Date
FOR GIRLS ONLY:		
Have you started your first p If yes, how old were you when period? What was the first day of you How often do you have your pe Have you been taught how to e lumps? Any additional comments or que	you had your fr last period?_riods?_xamine your bre	asts for YESNO
<u> </u>		*
Subsequent visits: Are there any changes in this visit? If yes, please describedate:	be changes, ini	tial, and
Are there any changes in this visit? If yes, please described date:	history since yoe changes, init	tial, and
Are there any changes in this visit? If yes, please describ		

date: