



Guidelines for Adolescent Preventive Services

Middle-Older Adolescent Questionnaire

Confidential

(Your answers will not be given out.)

Chart # _____

Name _____ Date _____
Last First Middle Initial

Date of Birth _____ Grade in School _____ Year in college _____ Sex: Male Female Age _____

Address _____ City _____ Zip _____

Phone number where you can be reached _____ Pager/beeper number _____

What languages are spoken where you live? _____ Race _____

Medical History

1. Why did you come to the clinic/office today? _____
2. Do you have any health problems? Yes No Problem(s) _____
3. Did you have any health problems in the past 12 months? Yes No Problem(s) _____
4. Are you taking any medicine now? Yes No Name of medicine _____

For Girls

5. Date when last period started _____ Are your periods regular (monthly)? No Yes
Month Date
6. Have you had a miscarriage, an abortion, or live birth in the past 12 months? Yes No

Specific Health Issues

7. Please check whether you have questions or are worried about any of the following:

<input type="checkbox"/> Height/weight	<input type="checkbox"/> Mouth/teeth/breath	<input type="checkbox"/> Frequent or painful urination	<input type="checkbox"/> Trouble sleeping
<input type="checkbox"/> Blood pressure	<input type="checkbox"/> Neck/back	<input type="checkbox"/> Discharge from penis or vagina	<input type="checkbox"/> Feeling tired a lot
<input type="checkbox"/> Diet/food/appetite	<input type="checkbox"/> Chest pain/trouble breathing	<input type="checkbox"/> Wetting the bed	<input type="checkbox"/> Cancer
<input type="checkbox"/> Future plans/job	<input type="checkbox"/> Coughing/wheezing	<input type="checkbox"/> Sexual organs/genitals	<input type="checkbox"/> Dying
<input type="checkbox"/> Skin (rash, acne)	<input type="checkbox"/> Breasts	<input type="checkbox"/> Menstruation/periods	<input type="checkbox"/> Sad or crying a lot
<input type="checkbox"/> Headaches/migraines	<input type="checkbox"/> Heart	<input type="checkbox"/> Wet dreams	<input type="checkbox"/> Stress
<input type="checkbox"/> Dizziness/fainting	<input type="checkbox"/> Stomach ache	<input type="checkbox"/> Physical or sexual abuse	<input type="checkbox"/> Anger/temper
<input type="checkbox"/> Eyes/vision	<input type="checkbox"/> Nausea/vomiting	<input type="checkbox"/> Masturbation	<input type="checkbox"/> Violence/personal safety
<input type="checkbox"/> Ears/hearing/ear aches	<input type="checkbox"/> Diarrhea/constipation	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Other (explain)
<input type="checkbox"/> Nose	<input type="checkbox"/> Muscle or joint pain in arms/legs		_____
<input type="checkbox"/> Lots of colds			_____

Health Profile

These questions will help us get to know you better. Choose the answer that best describes what you feel or do. Your answers will be seen only by your health care provider and his/her assistant.

Eating/Weight

8. Are you satisfied with your eating habits? No Yes
9. Do you ever eat in secret? Yes No
10. Do you spend a lot of time thinking about ways to be thin? Yes No
11. In the past year, have you tried to lose weight or control your weight by vomiting, taking diet pills or laxatives, or starving yourself? Yes No
12. Do you exercise or participate in sport activities that make you sweat and breathe hard for 20 minutes or more at a time at least three or more times during the week? No Yes

School

13. Are your grades this year worse than last year? Yes No Not in school
14. Have you either been told you have a learning problem or do you think you have a learning problem? Yes No
15. Have you been suspended from school this year? Yes No Not in school

Friends & Family

16. Do you have at least one friend who you really like and feel you can talk to? No Yes
17. Do you think that your parent(s) or guardian(s) usually listen to you and take your feelings seriously? No Yes
18. Have you ever thought seriously about running away from home? Yes No Not sure

Weapons/Violence/Safety

- 19. Do you or anyone you live with have a gun, rifle, or other firearm? Yes No Not sure
- 20. In the past year, have you carried a gun, knife, club, or other weapon for protection? Yes No
- 21. Have you been in a physical fight during the *past 3 months*? Yes No
- 22. Have you ever been in trouble with the law? Yes No
- 23. Are you worried about violence or your safety? Yes No Not sure
- 24. Do you usually wear a helmet when you rollerblade, skateboard, ride a bicycle , motorcycle, minibike, or ride in an all-terrain vehicle (ATV)? No Yes
- 25. Do you usually wear a seat belt when you ride in or drive a car, truck, or van? No Yes

Tobacco

- 26. Do you ever smoke cigarettes/cigars, use snuff or chew tobacco? Yes No
- 26. Do any of your close friends ever smoke cigarettes/cigars, use snuff or chew tobacco? Yes No
- 28. Does anyone you live with smoke cigarettes/cigars, use snuff or chew tobacco? Yes No

Alcohol

- 29. In the past month, did you get drunk or very high on beer, wine, or other alcohol? Yes No
- 30. In the past month, did any of your close friends get drunk or very high on beer, wine, or other alcohol? Yes No
- 31. Have you ever been criticized or gotten into trouble because of drinking? Yes No Not sure
- 32. In the past year have you used alcohol and then driven a car/truck/van/motorcycle? Yes No Does not apply
- 33. In the past year, have you been in a car or other motor vehicle when the driver has been drinking alcohol or using drugs? Yes No
- 34. Does anyone in your family drink or take drugs so much that it worries you? Yes No

Drugs

- 35. Do you ever use marijuana or other drugs, or sniff inhalants? Yes No Not sure
- 36. Do any of your close friends ever use marijuana or other drugs, or sniff inhalants? Yes No Not sure
- 37. Do you ever use non-prescription drugs to get to sleep, stay awake, calm down, or get high? (These drugs can be bought at a store without a doctor's prescription.) Yes No
- 38. Have you ever used steroid pills or shots without a doctor telling you to? Yes No Not sure

Development

- 39. Do you have any concerns or questions about the size or shape of your body, or your physical appearance? Yes No Not sure
- 40. Do you think you may be gay, lesbian, or bisexual? Yes No Not sure
- 41. Have you ever had sexual intercourse? (How old were you the first time? _____) Yes No Not sure
- 42. Are you using a method to prevent pregnancy? (Which: _____) No Yes Not active
- 43. Do you and your partner(s) *always* use condoms when you have sex? No Yes Not active
- 44. Have any of your close friends ever had sexual intercourse? Yes No Not sure
- 45. Have you ever been told by a doctor or nurse that you had a sexually transmitted infection or disease? Yes No Not sure
- 46. Have you ever been pregnant or gotten someone pregnant? Yes No Not sure
- 47. Would you like to receive information or supplies to prevent pregnancy or sexually transmitted infections? Yes No Not sure
- 48. Would you like to know how to avoid getting HIV/AIDS? Yes No Not sure
- 49. Have you pierced your body (not including ears) or gotten a tattoo? Yes No Thinking about it

Emotions

- 50. Have you had fun during the past two weeks? No Yes
- 51. During the past few weeks, have you *often* felt sad or down or as though you have nothing to look forward to? Yes No
- 52. Have you ever *seriously* thought about killing yourself, made a plan or actually tried to kill yourself? Yes No
- 53. Have you ever been physically, sexually, or emotionally abused? Yes No Not sure
- 54. When you get angry, do you do violent things? Yes No
- 55. Would you like to get counseling about something you have on your mind? Yes No Not sure

Special Circumstances

- 56. In the past year, have you been around someone with tuberculosis (TB)? Yes No Not sure
- 57. In the past year, have you stayed overnight in a homeless shelter, jail, or detention center? Yes No
- 58. Have you ever lived in foster care or a group home? Yes No

Self

- 59. What four words best describe you? _____
- 60. If you could change one thing about your life or yourself, what would it be? _____
- 61. What do you want to talk about today? _____