Teen Questionnaire for Teen Health Care Visit

marinhealth Medical Network | UCSF Health

Your Name: _____

Please answer the following questions. It will help your clinicians spend more time discussing those specific issues that concern you. PLEASE FILL OUT ALL SIDES.

Please list all the medications, vitamins, inhalers, or supplements that you are currently taking:			
Please list your medication or food allergies if any:			
Have you had any major medical problems since your last check up?	YES	NO	UNSURE
Do you have any injuries that still bother you?	YES	NO	UNSURE
Are your parent(s): Married Single Separated Divorced Other:			
SCHOOL:			
Current grade/name of school:			
Do you have any concerns about your performance in school?	YES	NO	UNSURE
Do your parents or teachers have concerns about your school performance?	YES	NO	UNSURE
What are your plans for after high school?			
NUTRITION:			
Are you unhappy with your weight?	YES	NO	UNSURE
Have you ever skipped meals, taken pills, or made yourself vomit to lose weight?	YES	NO	UNSURE
Are you a vegetarian?	YES	NO	UNSURE
Do you get at least 3 servings of milk or other calcium-containing foods daily?	YES	NO	UNSURE
Do you drink more than 6 oz of juice/soda/sports drinks daily?	YES	NO	UNSURE

PHYSICAL ACTIVITY:			
Aside from homework, how many hours a day are you using a TV, computer, or electronic device such as a tablet or your cell phone? 0-2 hours 2-4 hours 4+ hours			
Do you play on a school or club team? If so, what sports?			
Have you ever fainted while exercising?	YES	NO	UNSURE
Do you typically cough or have shortness of breath when you exercise?	YES	NO	UNSURE
Have you gotten aching chest pain when exercising?	YES	NO	UNSURE
Have you gotten a head injury in the last two years that affected sports or school?	YES	NO	UNSURE
Did anyone in your family die suddenly while exercising?	YES	NO	UNSURE
Has anyone in your family had a heart attack or stroke before age 55?	YES	NO	UNSURE
Do you get at least one hour of moderate strenuous activity daily?	YES	NO	UNSURE
SLEEP:			
Do you drink coffee, energy drinks, or caffeinated drinks? If yes, what kind and how many?	YES	NO	
Do you get at least 8 hours of sleep on a typical school night?	YES	NO	UNSURE
SAFETY:			
Do you wear sunglasses/hats/other sun protection measures outdoors?	YES	NO	UNSURE
Do you wear a seatbelt when riding in a car, truck or van?	YES	NO	UNSURE
Do you wear a helmet when skateboarding, rollerblading or riding a bicycle or scooter?	YES	NO	UNSURE
Does your home have smoke detectors?	YES	NO	UNSURE

Do students in your school carry guns or knives to school?	YES	NO	UNSURE
Are you worried about bullying, violence, or safety at your school?	YES	NO	UNSURE
Have you or your friends ever been in trouble with the police?	YES	NO	UNSURE
Is there a gun in your home?	YES	NO	UNSURE
SOCIAL HISTORY:			
Do you live in more than one home?	YES	NO	
Who lives with you? Please list (parents, sister, uncle, etc...):			
Do you have concerns about how your family gets along?	YES	NO	
Are you worried about violence and safety in your home?	YES	NO	
SUBSTANCE ABUSE:			
Do you smoke cigarettes, e-cigarettes, or chew tobacco?	YES	NO	
Does anyone in your home smoke cigarettes?	YES	NO	
Do you drink alcohol?	YES	NO	
Have you ever been drunk?	YES	NO	
Have you ever used drugs such as marijuana, ecstasy, meth or others?	YES	NO	
Do any of your friends smoke cigarettes, or chew tobacco, drink alcohol or use drugs?	YES	NO	
Have you ever driven or been in a car with a driver under the influence of drugs or alcohol?	YES	NO	
MENTAL HEALTH:			
In the past two weeks, how often have you been bothered by the following symptoms: Feeling down, depressed, irritable, hopeless?			
Not at all Several Days More than half the time Nearly Everyday			

Little interest or pleasure doing things? Not at all Several Days More than half the time Nearly Everyday				
Do you need help managing your stress?			YES	NO
SEXUAL HEALTH:				
Have you had sexual intercourse?			YES	NO
Do you need information about preventing pregnancy or sexually transmitted infections?			YES	NO UNSURE
Do you need information about bisexuality or being gay (homosexual)?			YES	NO UNSURE
Would you like a pregnancy test or sexually transmitted infection testing?			YES	NO UNSURE

Do you have any concerns that you would like to discuss today? If so, please list: