OBERLIN ROAD PEDIATRICS

Teen Questionnaire for Teen Health Care Visit (13-17 Y.O.)

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 BOTH 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 checkup?	No	Yes
Do you have any injuries that still bother you?	No	Yes

Are Parent(s) Married Unmarried Single Separated Divorced Other: _____

School

Current grade/ name of school:_____

Do you have concerns about your performance in school?	No	Yes
Do your parents or teachers have concerns about your school performance?	No	Yes

What are activities/interests/subjects that you enjoy? _____

_____

Are you unhappy with your weight?	No	Yes
Have you ever skipped meals, taken pills, or made yourself vomit to lose weight?	No	Yes
Do you eat meat (fish, chicken, pork or beef)?	Yes	No
Do you get at least 4 servings of milk or other calcium-containing foods daily?	Yes	No
Do you drink more than 6 oz. of juice/ soda/ sports drinks daily?	No	Yes

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 hrs	2-4 hrs	4+ hrs
Do you play on a school or club team? If so, what sport(s)?	No	Yes	

_____

Have you ever fainted while exercising?	No	Yes
Do you typically cough or have shortness of breath when you exercise?	No	Yes
Have you gotten aching chest pain when you exercise?	No	Yes
Has anyone in your family had a heart attack or stroke before age 55?	No	Yes
Did anyone in your family die suddenly while exercising?	No	Yes
Have you had a head injury in the last 2 years that affected sports or school?	No	Yes
Do you get at least one hour of moderately strenuous activity daily?	Yes	No
Do you drink coffee, energy drinks, or caffeinated drinks? If yes, what kind and how many? _____	No	Yes

_____

Do you get at least 8 hours of sleep on a typical school night?	Yes	No
Do you wear sunscreen/hats/other sun protection measures when outdoors?	Yes	No
Do you wear a seatbelt when riding in a car, truck or van?	Yes	No

CONTINUES ON OTHER SIDE

OBERLIN ROAD PEDIATRICS

Do you wear a helmet when skateboarding, rollerblading or riding a bicycle or scooter?	Yes	No
Does your home have smoke detectors?	Yes	No
Do students in your school carry guns or knives to school?	No	Yes
Are you worried about bullying, violence, or your safety at school?	No	Yes
Have you or your friends ever been in trouble with the police?	No	Yes
Is there a gun in your home?	No	Yes
Do you live in more than one home?	No	Yes

Who lives with you? Please list (parents, sister, uncle, etc…): _____

_____

Do you have concerns about how your family gets along?	No	Yes
Are you worried about violence or safety at your home?	No	Yes
Do you smoke cigarettes, vape or chew tobacco?	No	Yes
Does anyone in your home smoke cigarettes?	No	Yes
Do you drink alcohol?	No	Yes
Have you ever been drunk?	No	Yes
Have you ever used drugs such as marijuana, ecstasy, meth, or others?	No	Yes
Do any of your friends smoke cigarettes or vape, drink alcohol, or use drugs?	No	Yes
Have you ever driven or been in a car with a driver under the influence of drugs or alcohol?	No	Yes

PHQ-2

In the past two weeks, how often have you been bothered by the following symptoms:

1) Feeling down, depressed, irritable, or hopeless?

Not at all	Several Days	More than half of the time	Nearly every day

2) Little interest or pleasure in doing things?

Not at all	Several Days	More than half of the time	Nearly every day

Any Immediate Family history of mental health issues? No Yes

If yes, please explain: _____

_____

Have you ever had sexual intercourse?	No	Yes
Do you need information about preventing pregnancy or sexually transmitted infections?	No	Yes
Do you think you may be bisexual or gay (homosexual)?	No	Yes
Would you like a pregnancy test or sexually transmitted infection testing?	No	Yes

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

_____

_____

For Girls Only

Have you started your period?	Yes	No
Do you need help managing problems with your period?	No	Yes
Do you think your periods are heavy?	No	Yes