



## Teen Questionnaire for Teen Health Care Visit (18-22 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

If in school - current year / 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
Are you currently working or in the military?	No	Yes
What type of work or military service?		

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 3 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



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
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2) Little interest or pleasure in doing things?

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





### Risk Assessment for Tuberculosis Exposure/Infection:

Has a family member or contact had tuberculosis disease?	No	Yes
Since your child's last well check has a family member or contact had a positive tuberculosis test?	No	Yes
Was your child born in a high-risk country (Countries other than the United States, Canada, Australia, New Zealand, or western European countries)?	No	Yes
Has your child traveled to (or had contact with people who live in) a high-risk country for more than one week (Countries other than the United States, Canada, Australia, New Zealand, or western European countries)?	No	Yes

## SOCIAL DETERMINANTS OF HEALTH

There are programs to help people with needs that can affect their health, but they aren't reaching everyone who may need them. Are there things you need help with?

### Food

Within the past 12 months, did you worry that your food would run out before you got money to buy more?	No	Yes	
Within the past 12 months, did the food you bought just not last and you didn't have money to get more?	No	Yes	

### Interpersonal Safety

Do you feel physically or emotionally <u>unsafe</u> where you currently live?	No	Yes	
Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by someone?	No	Yes	
Within the past 12 months, have you been humiliated or emotionally abused in other ways by your partner or ex-partner?	No	Yes	