We ask all teenagers these questions because they are things that may affect your health. Some of these questions may not fit you.

We ask that you answer the questions alone, away from parents or friends, so you can be as honest as possible.

### Medications with Dose

<table>
<thead>
<tr>
<th>Medications with Dose</th>
<th>Reasons for Taking It</th>
<th>Types of Medication</th>
<th>Reactions/Side Effects</th>
</tr>
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### Hospitalizations (Illnesses or Operations):

<table>
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</table>

### Habits - Any problems with:

- Do you use tobacco? N Y [Amount/day:]
- Have you ever drunk alcohol? N Y [#Drinks/week:]
- Have you ever used drugs? N Y [Type/amount:]
- Do your friends use any of these substances? Y N
- Have you ever been in a car with a drunk driver? Y N
- Do you exercise? N Y [Method:]
- Do you play sports N Y [#Days/week:]
- Are you happy with your current weight? Y N
- How many hours/day do you watch TV? ____________
- How many hours do you sleep per night? ____________
- Do you wear safety belt in car & helmet on bicycle? Y N
- Do you feel you eat a healthy diet? Y N
- Are your immunizations up to date? Y N

**For females only:**

- How old were you when your first period began? Y N
- Have you had any sexual experiences? Y N
- What birth control method(s) do you use? ____________
- Have you ever been pregnant? ____________

**For males only:**

- Have you had any sexual experiences? Y N
- Do you use condoms? Y N
- Have you fathered any children? Y N

### Who do you live with?

- Do you get along with your family? Y N
- Do you work after school? N Y [#Hours/week:]
- Do you have a best friend? N Y
- Do you have a boyfriend/girlfriend? N Y
- What grade are you in? ____________

### What are your future plans? ____________

### List health concerns:

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<tr>
<th>Other:</th>
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Instructions: Please circle the symptoms below that you feel are affecting your health.

**General:** Fatigue, unexplained weight gain/loss, fever, chills, night sweats, feelings of anxiety/panic, episodes of crying/depression, serious thoughts of suicide.

**Skin:** New or changing skin growth, unexplained rash.

**Head:** Headaches, recent trauma.

**Eyes:** Blurred/loss of vision, eye pain, discharge, glasses/contacts.

**Ears:** Excessive noise exposure (loud music), ear pain, loss of hearing, ringing in ears.

**Nose:** Frequent bloody nose, sinus pain, post nasal drainage, congestion.

**Mouth:** Tooth pain, regular brushing/flossing and dental exams, oral sores.

**Throat:** Hoarse voice or pubertal voice changes, pain or difficulty swallowing.

**Neck:** Pain, stiffness, swelling.

**Chest:** Pubertal breast changes or lumps, nipple discharge, chest wall pain.

**Lungs:** Cough, shortness of breath, wheezing.

**Heart:** Murmurs, palpitations, pain with exertion, passing out.

**Stomach:** Frequent nausea, vomiting, diarrhea, constipation, abdominal pain, bleeding, constipation, difficulty with toilet training.

**Urinary Tract:** Frequent urination, pain on urination, blood in urine.

**Reproduction for Females:** Menstrual problems, vaginal discharge, sexually transmitted diseases, pelvic pain, bleeding, irritations, unprotected intercourse.

**Reproduction for Males:** Testicular pain, masses, penile discharge, sexually transmitted diseases, irritations, unprotected intercourse.

**Musculoskeletal:** Scoliosis, joint pain, swelling, muscle pain.

**Nervous System:** Loss of consciousness, dizziness, seizures, weakness or numbness in any body part.

**Social:** Excessive alcohol/drug use, use tobacco, have you been hit/insulted/threatened/ slapped by anyone?

Date ___________________ Patient Signature ___________________