Adolescent Health Questionnaire

Name: _____ **Birthdate:** _____
Today's Date: _____

This questionnaire helps you tell us about yourself. Answers are strictly confidential. ***Some statements may not apply to you, but please complete each one that applies to you carefully and honestly.*** Circle "Y" for YES or "N" for NO. If you do not understand a statement, mark it with a "?". Thank you.

SCHOOL _____ GRADE _____ JOB _____ HRS/WK _____

Who lives with you at home? (Please name all occupants of the house and their ages) Do they have any health problems?

_____

_____

What do you like to do when you are not in school? _____

Y N My health interferes with my school, work, or job.
Y N I am worried about my progress in school.
Favorite subject: _____ Most difficult subject: _____
Y N My appearance bothers me. If so, why? _____
Y N I am worried about my weight.
Y N I have acne, pimples or other skin problems I would like to clear up.
Y N Last dental exam: _____ Any problems? _____ Braces? _____
Y N I wear glasses or contact lenses. Last eye exam: _____
Y N I have hearing or other ear problems.
Y N Headaches are troublesome to me.
Y N I have fainting or dizzy spells.
Y N I get short of breath, cough, or wheeze too much.
Y N I get chest pain or shortness of breath with exercise.
Y N I have had a concussion or have been unconscious.
Y N I have had heat exhaustion, heat stroke or other problems with heat.
Y N Is there any reason why you should not participate in sports?
Y N Has any family member died at less than 40 years of age of causes other than an accident?
Y N Has any family member had a heart attack at less than 50 years of age?
Y N I have stomach aches often.
Y N Girls - I have cramps or other menstrual problems. My last period was _____
My period lasts _____ days.
Y N I have backaches, sore bones, foot or joint problems, neck, knee, or ankle injuries, broken bones (circle which)
Y N I have been hospitalized for illness, injury, or operation. Please describe: _____
_____
Y N I have allergies. Please describe: _____
Y N I take prescription medicines. Please describe: _____
Y N I get tired too easily.
Y N I often sleep poorly.
Y N I think I may be depressed.
Y N Making friends is hard for me.
Y N I smoke cigarettes. If so, how many in a day? _____
Y N I have tried drugs and/or alcohol.
Y N I use drugs or alcohol regularly. (at least once a week)
Y N I have questions about birth control and/or pregnancy.
Y N I have questions about AIDS or other sexually transmitted diseases.
Y N I have a boy/girl friend or I have started dating.
Y N I have had sexual relations.
Y N I have questions about sexual matters.
Y N I have questions about my sexual identity: homosexual, lesbian
Y N Have you ever been attacked or abused?
Y N My parents and I get along. My parents are: ☐ Married ☐ Separated ☐ Divorced ☐ Never Married
Y N I wear a seat belt: ☐Occasionally ☐ Usually ☐ Always
Y N When I ride a bike, I wear a bike helmet.

I would like to talk about: _____
My plans for the future are: _____