TRI-COUNTY FAMILY MEDICINE ASSOCIATES

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Parents:

- Please have your teen fill out form to the best of their ability by themselves.

- If you wish you may be present in the room for the beginning of the visit, the physical exam will be done with only the medical provider and patient in the room.

Why do we do this?

Teenagers' concerns about confidentiality can be a major barrier to obtaining health care. In a Louis Harris/Commonwealth Fund poll of more than six thousand five hundred teens, nearly one in three high-school girls and nearly one in four high-school boys admitted to at least one occasion when they needed medical care but did not see a doctor. The number-one reason given: They did not want their parents to know.

Teen History

Your Name: _____ Date of Birth: _____

Please answer all of the following questions. It will help your doctor spend more time discussing issues that may concern you

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

Do you live in more than one home? **Yes No**
Who lives with you? Please list (parents, sister, uncle, etc.): _____

Do you have dental exams (circle): **No Once a Year Twice a Year Only If Needed**
Do you have any piercings? **Yes No** If yes, where:_____
Do you have any tattoos? **Yes No** If yes, where:_____

School

Current grade:_____ Name of School: _____
Do you have concerns about how you are doing in school? **Yes No**
Do your parents or teachers have concerns about how you are doing in school? **Yes No**

Sleep

Do you drink coffee, energy drinks, tea, or caffeinated drinks **Yes No**
If yes, what kind and how many? _____
How many hours of sleep do you typically get?: _____ Do you have difficulty sleeping often? **Yes No**

Nutrition/Diet

Are you a vegetarian? **Yes No**
Are you unhappy with your weight? **Yes No**

Have you ever skipped meals, taken pills, or made yourself vomit to lose weight? **Yes No**
Do you get at least 3 servings of milk or other calcium-containing foods daily? **No Yes**

Do you drink more than 12 oz. of soda or sports drinks daily? **Yes No**
How many servings of fruits and vegetables do you eat each day: _____

Physical Activity

Do you get at least 30 minutes of moderate exercise/activity daily? **No Yes**
If no, how many days a week do you get exercise:_____
Do you play on a school or club team? **No Yes**
If yes, what sport(s)? _____
Have you ever fainted while exercising? **Yes No**
Do you cough or have shortness of breath when you exercise? **Yes No**
Have you gotten aching chest pain when you exercise? **Yes No**
Have you had a head injury in the last two years that affected sports or school? **Yes No**

Your Name: _____

Safety

Do you wear sunscreen, hats, or other sun protection measures when outdoors?	**No**	**Yes**	**Sometimes**
Do you wear a seatbelt when riding in a car, truck or van?	**No**	**Yes**	**Sometimes**
Do you wear a helmet when skating, rollerblading, riding a bicycle, scooter, ATV, dirt bike?	**No**	**Yes**	**Sometimes**
Does your home have smoke detectors?	**No**	**Yes**	
Does your home have carbon monoxide detectors?	**No**	**Yes**	
Are you worried about bullying, violence, or your safety at school?	**Yes**	**No**	
Do you have concerns about how your family gets along?	**Yes**	**No**	
Are you worried about violence or safety at your home?	**Yes**	**No**	

Drug/Substance Abuse

Have you ever smoked cigarettes, e-cigarettes, or chewed tobacco?	**Yes**	**No**	
Does anyone in your home smoke cigarettes?	**Yes**	**No**	
Have you ever drank alcohol or have you ever been drunk	**Yes**	**No**	
Have you ever used drugs such as marijuana, ecstasy, meth, heroin, or others?	**Yes**	**No**	
Have you ever driven or been in a car with a driver that had been drinking or using drugs?	**Yes**	**No**	

Emotional Health

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

Feeling down, depressed, irritable, or hopeless? **(Please circle below)**

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

Little interest or pleasure in doing things? **(Please circle below)**

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

Do you need help managing your stress?	**Yes**	**No**	
Have you ever made a plan to hurt yourself or others?	**Yes**	**No**	

Sexual Health

Have you ever had sexual intercourse?	**Yes**	**No**	
Has anyone ever forced you to have any type of sexual relations?	**Yes**	**No**	**Unsure**
Do you need information about preventing pregnancy or sexually transmitted infections?	**Yes**	**No**	**Unsure**
Would you like a pregnancy test or sexually transmitted infection testing?	**Yes**	**No**	**Unsure**
Do you need information about bisexuality, transgender or gay/homosexual?	**Yes**	**No**	**Unsure**

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

_____

_____

Would you like to have HIV testing?	**Yes**	**No**	**Unsure**

For Girls Only

Have you started your period?	**Yes**	**No**	
Do you need help managing problems with your period?	**Yes**	**No**	**Unsure**