Name: ___________________________________ DOB:______________ Patient cell #: _________________ Date: _____________

Preferred Name: ____________________ What pronouns do you use? ___He/his ___She/her ___They/their Other: ___________

ADOLESCENT HEALTH HISTORY FORM

These questions will help us get to know you better and provide better care for your needs. Please choose the answer that best describes what you feel or do. ***Your answers are private and will be seen only by your doctor and his/her assistant.***

General:

1. What grade are you in/will you be in? _______________________________________
2. What do you like to do outside of school? _______________________________________
3. Are you in any organized sports or activities? _______________________________________
4. Who lives in your house? _______________________________________
5. Do you feel like your housing is adequate? ___ No ___ Yes

School:

6. How do you feel about school? ___ *I like it a lot* ___ *I like it somewhat* ___ *I don't like it much* ____ *I hate it*
7. Are your grades worse this year than your grades the year before? ___ Yes ___ No
8. Are you in special education classes? ___ Yes ___ No
9. Have you been suspended from school this year? ___ Yes ___ No

Friends/Family:

10. Do you feel alone and unable to talk with close friends and family? ___ Yes ___ No
11. Have there been any recent changes in your living situation (divorce, etc?) ___ Yes ___ No
12. Have there been any serious illnesses recently in your family or a recent loss of a family member or friend?___ Yes ___ No
13. Do you feel unsafe in your house for any reason? ___ Yes ___ No

Safety:

14. Do you wear a seat belt? ___ No ___ Yes
15. Do you wear a bike helmet? ___ No ___ Yes
16. Are there guns in your house? ___ Yes ___ No
17. Have you witnessed or participated in a violent act in the past year? ___ Yes ___ No

Eating/Weight:

18. Do you have any concerns or questions about the size or shape of your body, or physical appearance? ___ Yes ___ No
19. At the present time, do you feel you are: ___ *Underweight* ___ *About right* ___ *Overweight*
20. Do you feel like you have enough food to eat? ___ No ___ Yes
21. Do you feel your eating habits are unhealthy? ___ Yes ___ No
22. Do you ever eat in secret? ___ Yes ___ No
23. In the past year have you ever tried to lose weight or control your weight by vomiting, taking diet pills or laxatives, or skipping meals? ___ Yes ___ No
24. Are you exercising **less** than 3 times per week? ___ Yes ___ No
25. Do you use exercise to lose or control your weight? ___ Yes ___ No
26. Do you have a special diet such as vegetarianism? ___ Yes ___ No

Social Media:

27. Do you use social media? ___ Yes ___ No If yes, which social media site/apps do you regularly use? ________________
28. How long do you spend on social media in a typical day? ____________________
29. Do you think you use social media too much? ___ Yes ___ No
30. Does viewing social media decrease your self-confidence? ___ Yes ___ No
31. Have you experienced cyberbullying, sexting, or has an online user asked to have sexual relations with you? ____Yes ___No

Tobacco:

32. Do any of your close friends smoke cigarettes, chew tobacco or use electronic cigarettes (e-cigs)? Vape? Juul?___Yes ___No
33. Does anyone you live with smoke cigarettes or chew tobacco? ___ Yes ___No
34. Do you ever smoke cigarettes or use smokeless tobacco (snuff/chew/vape/juul?) ___ Yes ___No

How much? _____________ *How often?*_________________

(PLEASE TURN OVER TO COMPLETE)

Alcohol:

35. Does anyone in your family have a problem with drugs or alcohol? ____Yes ___ No
36. In the past month, did any of your friends get drunk on beer, wine, wine coolers, or other alcohol? ____ Yes ___ No
37. In the past month, did you get drunk on beer, wine, wine coolers or other alcohol? ____ Yes ___ No
38. Have you ever gotten into trouble because of drinking? ____ Yes ___ No
39. Have you had any driving violations/tickets this year? ____ Yes ___ No
    If yes, were these related to alcohol or drug use? ____ Yes ___ No

Drugs:

40. Do any of your friends use marijuana, LSD, speed, ecstasy, meth, other drugs or inhalants (huffing)? ___ Yes ___ No
41. Do you ever use marijuana, LSD, speed, ecstasy, meth, or other drugs/inhalants? ___ Yes ___ No
42. Have you ever used steroids ("roids or juice")? ___ Yes ___ No
43. Do you ever use non-prescription drugs bought at a store to sleep, stay awake, calm down, or get high? ___ Yes ___ No

Sexuality:

44. Would you like information on body changes during adolescence? ___ Yes ___ No
45. Have you ever had sex? ___ Yes ___ No
    If you have had sex, how many partners have you had? ________
46. Have you ever had oral sex?
47. Are you using birth control? ___ Yes ___ No
    If yes, type: ________________________________
48. Do you and your partner ever forget to use condoms when you have sex? ___ Yes ___ No
49. Have you ever been tested for or had a sexually transmitted illness (STD/VD) such as genital herpes, gonorrhea, chlamydia, syphilis, genital warts (HPV) or AIDS/HIV? ___ Yes ___ No
50. Would you like information on birth control? ___ Yes ___ No
51. Would you like information on sex, STDs or HIV? ___ Yes ___ No
52. Would you like to be tested for HIV today? ___ Yes ___ No
53. Have you ever felt threatened in a relationship? ___ Yes ___ No
54. Have you ever been physically or sexually abused or raped? ___ Yes ___ No
55. Do you have any questions or concerns about your sexual attractions? ___ Yes ___ No
    - Are you attracted to: ____ *men* ____ *women* ____ *both*
56. Which best describes you? ____ *heterosexual (straight)* ____ *gay or lesbian* ____ *bisexual* ____ *not sure*

Self:

57. What is one thing you like about yourself? ______________________________________
58. What would you like to be when you grow up? __________________________________
59. If you could have 3 wishes come true, what would they be?
    - ____
    - ____
    - ____

For patients 18 years and over:

My Health

60. I know or can find my doctor's phone number. ____Yes ___ No, I need to learn
61. I make my own doctor appointments. ____Yes ___ No, I need to learn
62. I know where my pharmacy is and how to refill my medicines. ____Yes ___ No, I need to learn
63. I know my own medicines, what they are for, and when I need to take them. ____Yes ___ No, I need to learn
64. I know my allergies to medicines and medicines I should not take. ____Yes ___ No, I need to learn
65. I have a plan so I can keep my health insurance after 18 years or older. ____Yes ___ No, I need to learn
66. I have a copy of my insurance card. ____I don't have health insurance. ____Yes ___ No, I need to learn

Thank you very much for completing this form.

Office use only:

☐ Reviewed by Physician or CPNP Signature: ______________________________________