15 – 17 Year Questionnaire

Name:_____
D.O.B:_____

History

Do you, your parents, or anyone else have any concerns about health or well-being?
Yes No
Does you have any special health care needs?
Yes No
Have you seen another doctor are been in the hospital, emergency room or urgent care since your last visit?
Yes No
Do you receive care from anyone besides a medical doctor? For example, acupuncturist, herbalist or other healer.
Yes No
Have you had any procedures or tests done since their last visit?
Yes No

Household

How many people do you live with?_____
If you are not living with both biological parents, what is your living situation?
_____

Social History

Have there been any major changes for you or your family lately?
Yes No
Do you live with anyone who smokes or do you spend time in any places where people smoke? Does anyone smoke in the car you travel in?
Yes No

Anemia Risk Assessment

Has you ever been diagnosed with iron deficiency anemia?
Yes No
Are you on a strict vegetarian diet?
Yes No
Does your diet include iron-rich foods like meat, eggs, beans or iron-fortified cereals?
Yes No
FEMALES: When you get your period, are they heavy or last more than 5 days?
_____

Tuberculosis Risk Assessment

Have you been exposed to someone with tuberculosis?
Yes No
Has a family member or contact had a positive tuberculin skin test?
Yes No
Were you born in a country with a high risk of tuberculosis (countries other than of the US, Canada, Australia, New Zealand or Western Europe)?

Yes No
Have you traveled (and had contact with resident populations) for more than 1 week to a country at high risk for tuberculosis?
Yes No
Are you infected with HIV?
Yes No
Have you ever been in jail or incarcerated?
Yes No
Dyslipidemia Risk Assessment
Do your parents or grandparents had a stroke or heart problem before the age of 55?
Yes No
Do you have a parent or sibling that has high cholesterol (total cholesterol of 240 or higher) or taking cholesterol medication?
Yes No
Family and Home Life
How is everything at home?_____

Do you have chores to do at home?
Yes No
Do you get along with everyone you live with?
Yes No
Do you talk and/or spend time with your family on a regular basis?
Yes No
Do you have a family member or an adult who you can turn to for help?
Yes No
Education
If going to school, where?_____

How are you doing in school?_____
Are you having any problems at school?
Yes No
Do you have a job?_____
If you have a job, have you had any problems with work?
Ye No
What are your future education or work plans?

_____
Vision
Do you have trouble seeing the board in your classroom or seeing far away?
Yes No
Have you ever failed a school vision screening test?
Yes No
Do you hold reading material (books, magazines etc) close to your eyes to read?
Yes No
Do you have difficulty recognizing faces from far away?
Yes No
Do you tend to squint?
Yes No
Hearing

Do you have trouble hearing over the telephone?
Yes No
Do you have trouble following a conversation when 2 or more people are talking at the same time?
Yes No
Do you find yourself asking others to repeat themselves?
Yes No
Do you misunderstand what others say and respond inappropriately?
Yes No

Oral Health

Do you see the dentist at least every 6 months?_____

How often do you brush your teeth? _____
Do you drink water from a public water system that is fluoridated?
Yes No

Nutrition

How many meals do you eat a day?_____
How many cups of water do you drink a day?_____
How many cups of juice, soda, sports drinks, Kool-Aid or other drink mixes do you drink per day (total)?
_____
How would you describe your intake of dairy products like milk, cheese and yogurt?
_____

How would you describe your intake of vegetables?_____
How would you describe your intake of fruits?_____

How would you describe your intake of protein like meat and eggs?_____

How would you describe your intake of carbohydrates like grains, breads, cereals and pastas?
_____

How would you describe your intake of junk food like chips, candy, cookies, or cakes?
_____

Do you take vitamins or supplements?
Yes No
Do you have meals with your family?
Yes No

Physical Development

Are you satisfied with the way your body looks?
Yes No
Are you satisfied with your weight?
Yes No
What things have you tried to change the way your body looks?
_____

Physical Activity

Do you participate in exercise or physical activity?
Yes No

How long do you participate in physical activity?_____

How many hours do you spend watching TV a day? _____

Activities

Do you have any hobbies or interests?

Yes No

Substance Use

Have you ever smoked cigarettes, cigars, or chewed tobacco?

Yes No

Do you ever drink alcohol, like beer, wine, wine cooler, liquor or use alcohol soaked products?

Yes No

Do you use any drugs such as marijuana, cocaine, crack, heroin, or ecstasy?

Yes No

Do you take prescription medications that are not prescribed to you?

Yes No

Do you participate in recreational practices with the goal of getting high such as huffing, bath salts or the choking game?

Yes No

Risk-Taking Behavior

Do you have working smoke detectors at home?

_____

How often do you wear a seatbelt when riding in the car?

_____

Do you wear a helmet when riding a bike, skateboard, ATV, or motorcycle? What about while skiing, snowboarding, skating, mini-biking, or while on a snow mobile?

_____

Do you use protective sports gear (helmets, wrist guards, knee pads etc.)?

_____

Do you use life vests or life jacket aboard watercrafts like boats, canoes and jet skis?

_____

Do you use sunscreen or sun-protective garments/eyewear?_____

Do you use ear protection around loud noises?_____

Do you have your driver's license?_____

Have you ever driven a car after using alcohol or drugs?

Yes No

Have you ever been the passenger in a car after the driver had used alcohol or drugs?

Yes No

Have you ever used your phone while driving?

Yes No

Have you ever been upset over an experience you had while using the internet?

Yes No

Violence

Do you feel safe in your home, school, neighborhood or other places you spend time at?

Yes No

Have you ever been slapped, kicked, or physically hurt by someone?

Yes No

Do you have access to guns or other weapons at home?

Yes No

Are you in a gang?

Yes No

Have you been in a fight in the last year?

Yes No

Reproductive Health

What gender do you feel most sexually attracted to?_____

Have you ever had sex?

Yes No

Have you ever been pregnant or gotten someone pregnant?

Yes No

What are you or your partner using to prevent pregnancy? _____

Have you ever had a sexually transmitted disease?

Yes No

What are you using to prevent sexually transmitted diseases?

_____

How often do you practice safe sex, use your birth control method and/or condoms?

_____

Have you ever been tested for sexually transmitted diseases?

Yes No

Have you ever been forced to have sex you did not want to or touched you in a way that made you feel uncomfortable?

Yes No

FEMALES: Have you had your first period?

Yes No

FEMALES: If you have started getting your period, how often does it come?

_____

FEMALES: If you have started getting your period, how many days do they last for?

_____

Have you ever gotten a body piercing or a tattoo?_____

Mental Health

On average, how many hours of sleep do you get on a night?_____

Do you have a group of close friends?

Yes No

Do you often feel sad, down, or hopeless?

Yes No

Have you ever thought about hurting or killing yourself?
When you get angry, do you do violent things?
Yes No
Do you feel overly stressed out or worry a lot?
Yes No