PATIENT NAME:_____

PARENT QUESTIONNAIRE

Instructions: Thank you for taking the time to complete this questionnaire about your daughter. This information will be used to provide her with the best possible care.

1) Please let us know how to reach you in case we need additional information:

Your name: _____ E-mail: _____

Phone #1: (____) _____ Phone #2: (____) _____

2) Please mark any conditions that run in your family (on the patient's mother's or father's side).

❑ High blood pressure ❑ High cholesterol ❑ Obesity ❑ Diabetes mellitus ❑ Heart disease ❑ Death of a parent or grandparent from heart attack before age 55 years ❑ Stroke ❑ Death of a parent or grandparent from stroke before age 55 years ❑ Peripheral vascular disease ❑ Cerebrovascular disease ❑ Asthma ❑ Allergies ❑ Cancer (breast, colon, ovarian, or uterine) ❑ Seizures ❑ Eating disorder ❑ Anxiety ❑ Depression ❑ Bipolar disorder or other mental health issues ❑ Excessive bleeding or clotting problems ❑ Other (infertility, polycystic ovary syndrome, endometriosis, uterine leiomyomas, or genetic diseases)

If other, please explain_____

3) Has your daughter ever had surgery or been hospitalized?

❑ Yes ❑ No Please describe: _____

4) Please list all prescription and over-the-counter medications your daughter is taking, including any vitamins or supplements:

_____

5) Do you have concerns about your daughter's health or lifestyle?

❑ Yes ❑ No Please describe: _____

Have you talked with her about your concerns? ❑ Yes ❑ No

6) Have there been any changes, health problems, or stresses in your family this past year?

❑ Yes ❑ No Please describe: _____

7) Have you noticed any changes in your daughter's behavior, such as unusual anger or irritability, withdrawal, secrecy, sadness, depression, or problems at home or school?

❑ Yes ❑ No Please describe: _____

8) Do you think that smoking, drinking, or drug use is a problem for your daughter or anyone in your family?

❑ Yes ❑ No Please describe: _____

9) Is your daughter exposed to violence, such as hitting or fighting, in your home or community?

❑ Yes ❑ No Please describe: _____

10) What are your daughter's strengths and talents? _____

11) Would you like help talking with your daughter about sex, drinking, drugs, smoking, or other social issues?

❑ Yes ❑ No Please describe: _____

12) Is there anything you would like to discuss with the doctor or nurse today?

❑ Yes ❑ No Please describe: _____

13) Can we share your answers to any of the questions above with your daughter?

❑ Yes ❑ No Please explain: _____

Primary Care Physician:

Name:_____ Telephone #: _____

Who referred you?

Name:_____ Telephone #:_____

List other doctors or mental health counselors your daughter has seen in the past year:

Name:_____ Telephone #:_____

Name:_____ Telephone #: _____