

CONFIDENTIAL FORM

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ACOG ADOLESCENT VISIT QUESTIONNAIRE

We strongly encourage you to discuss all issues of your life with your parent(s) or guardian(s). However, unless it is a life threatening issue, the information you give us on this form is CONFIDENTIAL between our doctors and nurses and you. It will not be released without your written consent. If you would like help filling out this form, please let the nurse know. IF YOU DO NOT FEEL COMFORTABLE ANSWERING A QUESTION, LEAVE IT BLANK AND YOUR DOCTOR OR NURSE WILL TALK WITH YOU ABOUT IT.

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Why did you come into our office today? \_\_\_\_\_

General Health: Please answer these general health questions. Ignore the last column. Your doctor or nurse will fill that out.

Friends and Family		For doctor/nurse use
Can you talk with your parent(s) or guardian(s) about personal things happening in your life?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes	
Is there another adult you trust and can talk to if you have a problem?	<input type="checkbox"/> Yes <input type="checkbox"/> No Who?	
Who do you live with? (Please circle all that apply.)	Mother Father Guardian Brother or Sister Other:	
Do you think your family has lots of fun together?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes	
What do you do for fun?		
Do you think your parents care about you?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes	
Do you have a best friend?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
School and Work		
Do you like school?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes <input type="checkbox"/> Not in school	
What grade are you in?	Grade: _____ <input type="checkbox"/> Not in school	
What school do you go to?	School: _____ <input type="checkbox"/> Not in school	
Do you do well in school?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes <input type="checkbox"/> Not in school	
How often have you skipped school?	<input type="checkbox"/> Never <input type="checkbox"/> Once or twice <input type="checkbox"/> A lot	
Do you have any learning problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have a job?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, doing what?	
Do you know what you want to be when you are older?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what?	
Appearance and Fitness		
Do you have any concerns or questions about the shape or size of your body or the way you look?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	
Do you want to gain or lose weight?	<input type="checkbox"/> Gain <input type="checkbox"/> Lose <input type="checkbox"/> Neither	
Have you ever tried to lose weight or control your weight by throwing up, using diet pills or laxatives, or not eating for a day?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever had your body pierced (other than ears) or gotten a tattoo?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Considering	
Do you exercise or participate in a sport at least five times per week that makes you sweat or breathe hard for 30 minutes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
What sport, dance, or exercise programs do you participate in?		
How many fruits and vegetable portions do you eat each day?	<input type="checkbox"/> None <input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5-6 <input type="checkbox"/> 7 or more <input type="checkbox"/> Depends	
How many cups of milk, yogurt, ice cream do you eat each day?	<input type="checkbox"/> None <input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5-6 <input type="checkbox"/> 7 or more <input type="checkbox"/> Depends	

PATIENT NAME: \_\_\_\_\_

ACOG ADOLESCENT VISIT QUESTIONNAIRE (continued)

Safety/Weapons/Violence		For doctor/nurse use
Do you wear a seat belt when you ride in a car, truck, or van?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes	
Do you wear a helmet when you roller blade; skateboard; ride a bike, motorcycle, all-terrain vehicle, mini-bike, scooter; or go snowboarding or skiing? (Circle all activities in which you participate.)	<input type="checkbox"/> Yes, for all of the activities circled <input type="checkbox"/> No, for all of the activities circled <input type="checkbox"/> Sometimes If sometimes, please explain:	
Do you or does anyone you live with have a gun, rifle, or other firearm?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	
Have you ever carried a gun or weapon?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever been in trouble with the law?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Has anyone touched you in a way that made you uncomfortable?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	
Has anyone ever forced you to have sex?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	
Has anyone ever hurt you physically or emotionally?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	
<b>Relationships</b>		
Are you going out with anyone?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Who do you find yourself attracted to sexually?	<input type="checkbox"/> Boys <input type="checkbox"/> Girls <input type="checkbox"/> Both	
Do you ever participate in sexual activities, such as touching or oral or anal sex? If yes, do you use anything to prevent disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what do you use?	
Have you ever had sex with anyone? If yes, answer the questions in this section below. If no, do you plan to in the next year? When done answering this question, go to the section "Tobacco, Alcohol, and Drugs."	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	
How many sexual partners have you had in the past 3 months? How many total since you started to have sex?	Over past 3 months: Total:	
How old were you the first time you had sex (intercourse)?	Age:	
Have you ever had sex with a person of your same sex?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you use anything to prevent pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes If yes, what do you use?	
How often do you and your partner(s) use a condom when you have sex?	<input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Never	
Have you ever had sex for money or drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you worried about your parents knowing that you are having sex?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Tobacco, Alcohol, and Drugs</b>		
Have you or your close friends ever smoked cigarettes or cigars, used snuff, or chewed tobacco?	<input type="checkbox"/> Yes, I have <input type="checkbox"/> No, I have not <input type="checkbox"/> Yes, friends have <input type="checkbox"/> No, friends have not <input type="checkbox"/> Not sure about friends	
Have you or your close friends ever gotten drunk on wine, beer, or alcohol?	<input type="checkbox"/> Yes, I have <input type="checkbox"/> No, I have not <input type="checkbox"/> Yes, friends have <input type="checkbox"/> No, friends have not <input type="checkbox"/> Not sure about friends	
How much alcohol do you drink at one time?	<input type="checkbox"/> Do not drink <input type="checkbox"/> 1-2 drinks <input type="checkbox"/> 3 or more	
Do you ever have more than three drinks per occasion?	<input type="checkbox"/> Do not drink <input type="checkbox"/> Yes <input type="checkbox"/> No	
In the last year, have you been in a car or other motor vehicle when the driver is drunk or has been drinking alcohol or using drugs? (This includes when you were the driver as well as other people.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Would you call your parent(s) or guardian(s) for a ride if you needed to because the person who was supposed to drive you home had been drinking? (This includes when you were the driver as well as other people.)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	
Have you or your close friends ever used marijuana or other drugs (cocaine, heroin, meth, or ecstasy) or sniffed inhalants (glue, gasoline, or solvents)?	<input type="checkbox"/> Yes, I have <input type="checkbox"/> No, I have not <input type="checkbox"/> Yes, friends have <input type="checkbox"/> No, friends have not <input type="checkbox"/> Not sure	
Have you ever used a prescription drug to get high?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	

ACOG ADOLESCENT VISIT QUESTIONNAIRE (continued)

PATIENT NAME: \_\_\_\_\_

Have you ever used alcohol or drugs so much that you could not remember what happened (had a blackout)?	<input type="checkbox"/> Do not use drugs or alcohol <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever missed work or school because of using alcohol or drugs?	<input type="checkbox"/> Do not use drugs or alcohol <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Emotions</b>		
Do you have more happy days or unhappy days?	<input type="checkbox"/> Happy <input type="checkbox"/> Unhappy	
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you get nervous or anxious more than other people do?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
During the past year, have you had any major good or bad changes in your life (death of someone close, loss of a pet, birth, graduation, moving, change of school, ending or starting a close friendship or romantic relationship)?	<input type="checkbox"/> Good <input type="checkbox"/> Bad <input type="checkbox"/> No changes <input type="checkbox"/> Some good, some bad	
Tell me something good about yourself.		

What would you like to discuss with our nurses and doctors today? \_\_\_\_\_

Source: American Medical Association, Copyright 1998.