FEMALE ADOLESCENT QUESTIONNAIRE

Today's Date: _____ Age: _____ Date of Birth: ____/____/_____

Who lives at your home? _____
Do you have a job / volunteer work outside of school: _____

IT IS THE POLICY IN OUR MEDICAL PRACTICE THAT ALL INFORMATION TEENAGERS SHARE WITH OUR DOCTORS AND NURSES IS CONFIDENTIAL, UNLESS THAT INFORMATION ENDANGERS THE LIFE OF THE TEEN OR OF SOMEONE ELSE. HOWEVER, WE ENCOURAGE YOU TO DISCUSS THESE HEALTH MATTERS WITH YOUR PARENTS.

CIRCLE ANY of the following that concern you or that you have questions about:

	Sexually Transmitted	Constipation	Weight
AIDS	Diseases	Family problems	Nutrition
Alcohol	Acne	Mother/Father problems	Exercise
Drugs	Body Odor	Sister/Brother problems	School
Tobacco use	Breast Changes Growth	Physical/Sexual abuse Suicide	Sports
Sex questions	Bedwetting	Depression	Hearing voices
Pregnancy / Birth control	Headaches	Fear	Visions
Masturbation	Pain	Marriage	Other _____
Homosexuality	Vaginal Discharge	Death	

PLEASE TRY TO ANSWER ALL OF THE FOLLOWING QUESTIONS
IF YOU DO NOT UNDERSTAND SOMETHING, PUT A CHECKMARK BESIDE IT.

We have included the following questions because we feel that these areas affect your physical and emotional health.

1. Have you ever smoked cigarettes, a pipe, or cigars, or used dip, snuff, or other tobacco products? _____ If yes, how much and when did you start? _____ 2. Do you / did you ever drink alcohol? _____ If yes, how much and when do you usually drink it? _____ 3. Have you ever been in a car when the driver had been drinking or using any drugs? _____ If yes, how often? _____ 4. Do you / did you ever smoke marijuana? _____ 5. Have you used steroids? _____ If yes, how often? _____ 6. Do you/ did you ever take other "street" drugs? _____ 7. What non-prescription drugs from the drug store do you use?

1) _____ 2) _____ 3) _____ 4) _____ 8. Do you always wear a seatbelt in the car? _____

9. Have you menstruated yet? _____ How old were you: _____ How often do you menstruate? _____

10. Do you douche? _____ If yes, how often? _____

11. Where have you learned the most about sexuality? (circle one)

Parents Friends Books/internet TV/movies School Sister/Brother Boyfriend Other _____ 12. Have you ever had sexual intercourse? _____ If yes, how old were you the first time? _____ When was the last time? _____ What kind of birth control do you use? _____ 13. Have you ever been pregnant? _____ If yes, when? _____ 14. Young women sometimes have sexual thoughts or feelings about other females, have you? _____ 15. Do you have a steady boyfriend? _____ If yes, how old is he? _____

Patient Name: _____ Language: E S Other _____

16. If you go to school, what grade are you in? _____ Have you ever been held back a grade? _____ What are your average grades? _____ What activities are you in at school besides classes? _____ 17. If you are not in school, what grade did you finish? _____
18. Do you have trouble sleeping? _____ How is your mood? _____ Are you ever depressed? _____
19. Have you ever been in trouble with the law? _____ When? _____
20. Have you ever thought of suicide? _____ If yes, when? _____
21. Have you ever broken any of your bones? _____ If yes, when? _____
22. Have you ever been in an accident? _____ When? _____
23. Have you ever spent the night in the hospital? _____ When? _____
24. Do you do any regular exercise? _____ If yes, what? _____
25. List any sports injuries you have had that stopped you from playing _____
26. What are your hobbies and/or interests? _____
27. What is your favorite TV show? _____
28. Have you ever been knocked unconscious or fainted? _____
29. How do you see yourself as an adult? _____
30. Do you ever think you are different from everyone else? _____
31. How do you protect yourself from AIDS? _____
32. What role, if any, does religion or spirituality play in your life? _____
33. Has anyone ever touched you in places or ways that you felt were wrong, inappropriate, or that made you feel uncomfortable, guilty, or afraid? _____ 34. What are you really good at? _____ 35. Are you comfortable discussing the issues above with your parents? _____

Please write down what you eat on an average day:
Breakfast _____
Lunch
_____
Dinner
_____
Snacks
_____

SPACE BELOW - FOR DOCTOR USE ONLY

General Comments:
_____
_____
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_____
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_____
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_____
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Reviewed by ______________________________________ Date ___________________

Patient Name: ______________________________

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