CHILDREN FIRST
DUMFRIES PEDIATRICS

Teen Questionnaire for Teen Health Care Visit

Your Name: _____

Please answer the following questions. It will help your clinicians spend more time discussing those specific issues that concern you. PLEASE FILL OUT BOTH SIDES.

Please list all the medications, vitamins, inhalers or supplements that you are currently taking:

_____

Please list your medication or food allergies, if any:

_____

Have you had any major medical problems since your last checkup?	Yes	No	Unsure
Do you have any injuries that still bother you?	Yes	No	Unsure

Are Parent(s): Married Unmarried Single Separated Divorced Other: _____

School

Current grade/ name of school: _____

Do you have concerns about your performance in school?	No	Yes	Unsure
Do your parents or teachers have concerns about your school performance?	No	Yes	Unsure

What are your plans after high school?

_____

Nutrition

Are you unhappy with your weight?	No	Yes	
Have you ever skipped meals, taken pills, or made yourself vomit to lose weight?	No	Yes	
Are you a vegetarian?	No	Yes	
Do you get at least 3 servings of milk or other calcium-containing foods daily?	Yes	No	
Do you drink more than 6 oz. of juice/ soda/ sports drinks daily?	No	Yes	

Physical Activity

Aside from homework, how many hours a day are you using a TV, computer, or electronic device such as a tablet or your cell phone?	0-2 hrs/	2-4 hrs/	4+ hrs
Do you play on a school or club team? If so, what sport(s)?	No	Yes	

_____

Have you ever fainted while exercising?	No	Yes	
Do you typically cough or have shortness of breath when you exercise?	No	Yes	
Have you gotten aching chest pain when you exercise?	No	Yes	
Have you had a head injury in the last two years that affected sports or school?	No	Yes	
Did anyone in your family die suddenly while exercising?	No	Yes	Unsure
Has anyone in your family had a heart attack or stroke before age 55?	No	Yes	Unsure
Do you get at least one hour of moderately strenuous activity daily?	Yes	No	

Sleep

Do you drink coffee, energy drinks, or caffeinated drinks?	No	Yes	

If yes, what kind and how many? _____

Do you get at least 8 hours of sleep on a typical school night?	Yes	No	Unsure

Safety

Do you wear sunscreen/hats/other sun protection measures when outdoors?	Yes	No	Unsure
Do you wear a seatbelt when riding in a car, truck or van?	Yes	No	Unsure

CONTINUES ON OTHER SIDE

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Safety Continued:

Do you wear a helmet when skateboarding, rollerblading, or riding a bicycle or scooter?	Yes	No	Unsure
Does your home have smoke detectors?	Yes	No	Unsure
Do students in your school carry guns or knives to school?	No	Yes	Unsure
Are you worried about bullying, violence, or your safety at school?	No	Yes	Unsure
Have you or your friends ever been in trouble with the police?	No	Yes	Unsure
Is there a gun in your home?	No	Yes	Unsure

Social History

Do you live in more than one home?	No	Yes
Who lives with you? Please list (parents, sister, uncle, etc…): _____		
Do you have concerns about how your family gets along?	No	Yes
Are you worried about violence or safety at your home?	No	Yes

Substance Abuse

Do you smoke cigarettes, e-cigarettes, or chew tobacco?	No	Yes
Does anyone in your home smoke cigarettes?	No	Yes
Do you drink alcohol?	No	Yes
Have you ever been drunk?	No	Yes
Have you ever used drugs such as marijuana, ecstasy, meth, or others?	No	Yes
Do any of your friends smoke cigarettes or chew tobacco, drink alcohol, or use drugs?	No	Yes
Have you ever driven or been in a car with a driver under the influence of drugs or alcohol?	No	Yes

Mental Health

In the past two weeks, how often have you been bothered by the following symptoms:

Feeling down, depressed, irritable, or hopeless?

Not at all/ Several Days/ More than half of the time/ Nearly every day

Little interest or pleasure in doing things?

Not at all/ Several Days/ More than half of the time/ Nearly every day

Do you need help managing your stress?	No	Yes

Sexual Health

Have you ever had sexual intercourse?	No	Yes	Unsure
Do you need information about preventing pregnancy or sexually transmitted infections?	No	Yes	Unsure
Do you need information about bisexuality or being gay (homosexual)?	No	Yes	Unsure
Would you like a pregnancy test or sexually transmitted infection testing?	No	Yes	Unsure

Do you have any concerns that you would like to discuss today? If so, please list:

_____

_____

_____

For Girls Only

Have you started your period?	Yes	No
Do you need help managing problems with your period?	No	Yes

CONTINUES ON OTHER SIDE