Adolescent Health Questionnaire

Your Name: _____ Your Date of Birth: _____ Date of Visit: _____

Please fill out this questionnaire. We will appreciate your honest answers, so we can serve you better. This information is part of your confidential medical record. It will be released only after a court order for your records is received.

Please check if questionnaire filled out by healthcare provider by directly collecting the information from the adolescent during the medical evaluation ☐

1. Do you smoke cigarettes? ☐ Yes ☐ No
   If yes, how many cigarettes a day? _____
2. Have you ever tried alcoholic beverages? ☐ Yes ☐ No
   If yes, what kind have you tried? _____
3. Are you currently drinking any alcoholic beverages? ☐ Yes ☐ No
   If yes, what kind are you drinking? _____
   How many days a week do you drink? _____
   How many drinks during those days? _____
4. Have you ever tried drugs? ☐ Yes ☐ No
   If yes, which drugs have you tried? _____
5. Are you currently using drugs? ☐ Yes ☐ No
   If yes, what drug(s) are you using? _____
   How often? _____
6. Have you ever had **thoughts** of hurting yourself? ☐ Yes ☐ No
   If yes, when was the last time you had those thoughts? _____
   Did you have a plan of how to hurt yourself? ☐ Yes ☐ No
   If yes, please describe your plan. _____
   _____
7. Have you ever **tried** to hurt yourself? ☐ Yes ☐ No
   If yes, how did you try to hurt yourself? _____
   How many times have you tried to hurt yourself? _____
   Have you ever been admitted to a hospital for these attempts? ☐ Yes ☐ No
   Have you received any treatment or medications? ☐ Yes ☐ No
   If yes, what medications? _____
   For how long? _____ Are you still taking the medications? ☐ Yes ☐ No
8. Have you ever willingly had sex? ☐ Yes ☐ No
   If yes, how many different partners have you had sex with? _____
   When was the last time you had sex? _____
9. Have you ever had sex without a condom? ☐ Yes ☐ No
   If yes, how many partners have you had sex with and not used condoms? _____
10. Is there anything else that you would like to discuss with the doctor? _____
    _____

For females only:

1. How old were you when you had your first period? _____ What is the date of your last period? _____
2. Have you ever used birth control that was prescribed by a doctor? ☐ Yes ☐ No
   If yes, what kind? _____

Reviewed by: _____ **Date:** _____
Healthcare Provider