Patient Questionnaire (Middle/Older Teen)

PATIENT NAME:_____ **DOB:**_____

TODAY'S DATE:_____ **SEX:**_____

APPOINTMENT: General checkup or specific concern (circle one)

SPECIFIC CONCERN:_____

UPDATE:

Changes in your life since last visit:_____

What do you like about yourself?_____

If you could change one thing in your life:_____

RECENT CHANGES/STRESSORS:

Move Y/N **Death Y/N** **New School Y/N**

Parent Loss of Job Y/N **Illness Y/N** **Parent Separation or divorce Y/N** **Other**_____

ACADEMIC

Current Grade:_____ **What grades do you get?** _____ **Are you comfortable with your grades? Y/N**

ACTIVITY/SLEEP

Number of days in a week you exercise/sports: _____

Screen time (Phone/TV/Computer/videogames/iPad): Weekdays- <2 hr or >2 hr

Weekends- <2 hr or >2 hr

Family dinners together in a week: <3/week or >3/week

Sleep hours at night: Weekdays <6hrs 6-8hrs >8hrs

Weekends <6hrs 6-8hrs >8hrs

NUTRITION/BODY IMAGE

Number of times you eat fast food: **None** **1-3/week** **4-7/week**

Number of times you drink juice/soda/sports drinks: **None** **1-3/week** **4-7/week**

Vegetarian/Vegan diet: Y/N

Vitamins/Supplements_____

Any concerns about weight or eating habits Y/N_____

Lake Lewisville Pediatrics
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972 315 8500

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IN THE PAST YEAR….

How often do you feel extremely worried? Rarely Sometimes Often

How often do you feel extremely sad or hopeless? Rarely Sometimes Often

Have you ever wished you were dead? Yes No

Have you ever felt that you or your family would be better off if you were dead?

Yes No

Have you thought about running away from home Yes No

Have you thought about killing yourself? Yes No

Have you ever been a victim of abuse (emotional/physical/sexual)? Yes No

If yes, then explain_____

How often have you smoked or used tobacco? Never Sometimes Often

How often have you consumed alcohol? Never Sometimes Often

How often have you consumed illegal drugs? Never Sometimes Often

Have you been sexually active (vaginal intercourse/oral sex/anal sex)?

Never Yes Not sure

Are your parents/guardians aware? Yes No

MENSTRUAL HISTORY (Girls only)

Age of first period: Not started Age_____

Date of last menstrual period_____

Periods Regular Irregular

Cramping None Mild Moderate Severe

Have you ever been pregnant? No Yes

Have you ever had an abortion or miscarriage? No Yes Not sure

Have you ever had a sexually transmitted disease? No Yes Not sure

Have you ever been forced to have sex by anyone? No Yes Not sure

Have you ever been attracted to someone of the same sex? No Yes Not sure

MAY WE SHARE THESE ANSWERS WITH YOUR PARENTS? YES NO

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