13 - 18 yrs. old

TEEN HEALTH QUESTIONNAIRE

Name_____ Date_____

Please check which problems you have had in the past:

___Allergies/hay fever
___Asthma
___Bladder or kidney infection
___Blood disorder/sick cell anemia
___Cancer
___Chickenpox
___Depression
___Diabetes
___Eating disorder
___Emotional disorder
___Hepatitis (liver disease)
___Headaches/migraines
___Low iron in blood (anemia)
___Mononucleosis ("Mono")
___Pneumonia
___Rheumatic fever or heart disease
___Scoliosis (curved spine)
___Seizures/epilepsy
___Severe acne
___Stomach problems
___Tuberculosis
___Other problem not listed_____

Serious injuries:_____

Operations:_____

Do you use any special equipment or corrective devices (glasses, contacts, braces, special shoes, special taping or care for joints, braces, etc)?

_____

Please check if you have had bad strains or sprains, fractures or dislocations of any of these:

___Neck ___Upper arm ___Hand ___Knee
___Back ___Elbow ___Finger ___Ankle
___Chest ___Forearm ___Hip
___Shoulder ___Wrist ___Thigh ___Foot

Does any sport you play have a weight requirement?	No	Yes
Do you have to lose or gain weight regularly to meet this requirement?	No	Yes
When you exercise or participate in sports, have you ever had nausea?	No	Yes
Dizziness?	No	Yes
Chest pain?	No	Yes
Trouble breathing?	No	Yes
Wheezing?	No	Yes
Coughing?	No	Yes
A "stinger" or "burner"	No	Yes
"pinched nerve"	No	Yes
Have you ever hurt your head bad enough that you threw up or was knocked out?	No	Yes
Have you ever passed out or fainted?	No	Yes
Have you noticed that you tire more easily than your friends or teammates?	No	Yes
Have you ever had racing of your heart or skipped heart beats?	No	Yes
Have you ever been told that you had a heart murmur or heart rhythm disturbance	No	Yes
Have you ever had numbness or tingling in your arms, legs, or feet?	No	Yes
In the last month, have you had any severe infection?	No	Yes
Have you ever been restricted from participating in sports for any health problems?	No	Yes
Are you missing any of your "paired" organs (for example, missing a kidney, an eye, etc.)	No	Yes
Have you ever been told that you have high blood pressure or high cholesterol?	No	Yes
Has anyone in your family ever suddenly collapsed during sports or exercise?	No	Yes
Have you ever passed out or threw up because you got overheated?	No	Yes
Have you seen a dentist in the last year?	Yes	No

GUYS, cancer of the testes is most commonly found in men between the ages of 15 and 35. So....

Do you know how to check your testes for this?	Yes	No
Do you check yourself regularly?	Yes	No

GIRLS, Have you started your periods?_____ How old were you when you had your first period?_____

Are your periods regular?_____ How long do they last?_____

When was your last period?_____

Answers to the following questions are important in evaluating your health. These answers are confidential and will not be shared with anyone except the person doing your check up--unless YOU share them yourself.

Do you believe you should weigh more or less than you do now? Less More I'm about right

Have you ever been **so worried** about your weight that you have tried taking laxatives, vomited or starved yourself to take some weight off? No Yes

If you could, would you change anything about how your body looks? No Yes

Do you take any nutritional supplements, vitamins or medicines to build up your body's strength or size? No Yes

Do you like school? Yes No

Do you get along well with the teachers at school? Yes No

Have you ever been told that you have a learning problem? No Yes

Do you have good friends you like being with? Yes No

Have you ever been afraid that someone would seriously hurt you? No Yes

Do you usually wear a seat belt when driving or riding? Yes No

If you ride a bike, rollerblades or skateboard, do you wear a helmet? Yes No Don't ride or skate

Have you ever been in a car/vehicle when the driver has been drinking Or using drugs? No Yes

Do you use tobacco in any form? (smoke, chew) No Yes

Does anyone you live with use tobacco? No Yes

Have you ever used marijuana or other "drugs"? No Yes

Have you ever used drugs that you inject into your body? No Yes

Have you ever used medicines to get to sleep, stay awake, calm down or get high? No Yes

How many drinks/beers would it take to make YOU drunk? 5 or more 3-4 1-2 Don't know I don't drink

Have you ever had sexual intercourse? No Yes

Are you sexually active right now? No Yes

If you are sexually active, are you doing something to avoid pregnancy? Yes No

If you are sexually active, are you doing something to avoid getting diseases? Yes No

Do you have any piercings (NOT including ears) or tattoos? No Yes

Do you know how HIV/AIDS or Hepatitis B is spread? Yes Think so No

Do you believe that you have a generally good life? Yes No

Do you know a priest, rabbi or minister that would be of help if you needed spiritual help? Yes No

Would you like to get counseling for something that is bothering you? No Yes

In the past year, have you been around someone with TB No Yes

Stayed in a homeless shelter, jail or detention center? No Yes

Have you ever lived in foster care or a group home? No Yes

In the past year, has your family been through big changes that have made you feel stressed? (marriage, separation, divorce, loss of job, moving, new school, birth, death, serious illness) No Yes

Do you have any relatives with "high cholesterol"? No Yes

Have your parents or grandparents had a stroke or heart attack BEFORE age 55? No Yes

Do you have a job? No Yes

If yes, what is it and how many hours a week do you work?_____

With whom do you live?_____
(parents, foster parents guardians, brothers, sisters, etc)

What four words to describe you?_____

What are you going to be when you are older?_____

If you could change one thing about your life, what would it be?_____

Is there anything worrying you that you would like help with?_____