**PARENT QUESTIONNAIRE**

Instructions: Thank you for taking the time to complete this questionnaire about your daughter. This information will be used to provide her with the best possible care.

1) Please let us know how to reach you in case we need additional information:

<table>
<thead>
<tr>
<th>Name: __________________________</th>
<th>E-mail: ____________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone #1: (______) _____________</td>
<td>Phone #2: (______) _________________</td>
</tr>
</tbody>
</table>

2) Please mark any conditions that run in your family (on the patient’s mother’s or father’s side):

- [ ] High blood pressure
- [ ] High cholesterol
- [ ] Obesity
- [ ] Diabetes mellitus
- [ ] Heart disease
- [ ] Death of a parent or grandparent from heart attack before age 55 years
- [ ] Stroke
- [ ] Death of a parent or grandparent from stroke before age 55 years
- [ ] Peripheral vascular disease
- [ ] Cerebrovascular disease
- [ ] Asthma
- [ ] Allergies
- [ ] Cancer (breast, colon, ovarian, or uterine)
- [ ] Seizures
- [ ] Eating disorder
- [ ] Anxiety
- [ ] Depression
- [ ] Bipolar disorder or other mental health issues
- [ ] Excessive bleeding or clotting problems
- [ ] Other (infertility, polycystic ovary syndrome, endometriosis, uterine leiomyomas, or genetic diseases)

If other, please explain ____________________________________________________________

3) Has your daughter ever had surgery or been hospitalized?

- [ ] Yes
- [ ] No

Please describe: __________________________________________________________________

4) Please list all prescription and over-the-counter medications your daughter is taking, including any vitamins or supplements:

________________________________________________________________________________

5) Do you have concerns about your daughter’s health or lifestyle?

- [ ] Yes
- [ ] No

Please describe: __________________________________________________________________

Have you talked with her about your concerns? [ ] Yes [ ] No

6) Have there been any changes, health problems, or stresses in your family this past year?

- [ ] Yes
- [ ] No

Please describe: __________________________________________________________________

7) Have you noticed any changes in your daughter’s behavior, such as unusual anger or irritability, withdrawal, secrecy, sadness, depression, or problems at home or school?

- [ ] Yes
- [ ] No

Please describe: __________________________________________________________________

8) Do you think that smoking, drinking, or drug use is a problem for your daughter or anyone in your family?

- [ ] Yes
- [ ] No

Please describe: __________________________________________________________________

9) Is your daughter exposed to violence, such as hitting or fighting, in your home or community?

- [ ] Yes
- [ ] No

Please describe: __________________________________________________________________

10) What are your daughter’s strengths and talents?

________________________________________________________________________________

11) Would you like help talking with your daughter about sex, drinking, drugs, smoking, or other social issues?

- [ ] Yes
- [ ] No

Please describe: __________________________________________________________________

12) Is there anything you would like to discuss with the doctor or nurse today?

- [ ] Yes
- [ ] No

Please describe: __________________________________________________________________

13) Can we share your answers to any of the questions above with your daughter?

- [ ] Yes
- [ ] No

Please explain: ___________________________________________________________________

Primary Care Physician:

Name: __________________________ Telephone #: __________________________

Who referred you?

Name: __________________________ Telephone #: __________________________

List other doctors or mental health counselors your daughter has seen in the past year:

| Name: __________________________ Telephone #: __________________________ |
|-----------------------------|---------------------------------|
| Name: ________________________ Telephone #: __________________________ |
| Name: ________________________ Telephone #: __________________________ |
ACOG ADOLESCENT VISIT QUESTIONNAIRE

We strongly encourage you to discuss all issues of your life with your parent(s) or guardian(s). However, unless it is a life threatening issue, the information you give us on this form is CONFIDENTIAL between our doctors and nurses and you. It will not be released without your written consent. If you would like help filling out this form, please let the nurse know. IF YOU DO NOT FEEL COMFORTABLE ANSWERING A QUESTION, LEAVE IT BLANK AND YOUR DOCTOR OR NURSE WILL TALK WITH YOU ABOUT IT.

Name: ___________________________________________ Age: ____________ Today's Date: ________________________

Why did you come into our office today? __________________________________________________________________________________________

General Health: Please answer these general health questions. Ignore the last column. Your doctor or nurse will fill that out.

<table>
<thead>
<tr>
<th>Friends and Family</th>
<th>For doctor/nurse use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can you talk with your parent(s) or guardian(s) about personal things happening in your life?</td>
<td>J Yes J No J Sometimes</td>
</tr>
<tr>
<td>Is there another adult you trust and can talk to if you have a problem?</td>
<td>J Yes J No Who?</td>
</tr>
<tr>
<td>Who do you live with? (Please circle all that apply.)</td>
<td>Mother Father Guardian Brother or Sister Other:</td>
</tr>
<tr>
<td>Do you think your family has lots of fun together?</td>
<td>J Yes J No J Sometimes</td>
</tr>
<tr>
<td>What do you do for fun?</td>
<td></td>
</tr>
<tr>
<td>Do you think your parents care about you?</td>
<td>J Yes J No J Sometimes</td>
</tr>
<tr>
<td>Do you have a best friend?</td>
<td>J Yes J No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>School and Work</th>
<th>For doctor/nurse use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you like school?</td>
<td>J Yes J No J Sometimes J Not in school</td>
</tr>
<tr>
<td>What grade are you in?</td>
<td>Grade: J Not in school</td>
</tr>
<tr>
<td>What school do you go to?</td>
<td>School: J Not in school</td>
</tr>
<tr>
<td>Do you do well in school?</td>
<td>J Yes J No J Sometimes J Not in school</td>
</tr>
<tr>
<td>How often have you skipped school?</td>
<td>J Never J Once or twice J A lot</td>
</tr>
<tr>
<td>Do you have any learning problems?</td>
<td>J Yes J No</td>
</tr>
<tr>
<td>Do you have a job?</td>
<td>J Yes J No J If yes, doing what?</td>
</tr>
<tr>
<td>Do you know what you want to be when you are older?</td>
<td>J Yes J No J If yes, what?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Appearance and Fitness</th>
<th>For doctor/nurse use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have any concerns or questions about the shape or size of your body or the way you look?</td>
<td>J Yes J No J Not sure</td>
</tr>
<tr>
<td>Do you want to gain or lose weight?</td>
<td>J Gain J Lose J Neither</td>
</tr>
<tr>
<td>Have you ever tried to lose weight or control your weight by throwing up, using diet pills or laxatives, or not eating for a day?</td>
<td>J Yes J No</td>
</tr>
<tr>
<td>Have you ever had your body pierced (other than ears) or gotten a tattoo?</td>
<td>J Yes J No J Considering</td>
</tr>
<tr>
<td>Do you exercise or participate in a sport at least five times per week that makes you sweat or breathe hard for 30 minutes?</td>
<td>J Yes J No</td>
</tr>
<tr>
<td>What sport, dance, or exercise programs do you participate in?</td>
<td>J None J 1–2 J 3–4 J 5–6 J 7 or more J Depends</td>
</tr>
<tr>
<td>How many fruits and vegetable portions do you eat each day?</td>
<td>J None J 1–2 J 3–4 J 5–6 J 7 or more J Depends</td>
</tr>
<tr>
<td>How many cups of milk, yogurt, ice cream do you eat each day?</td>
<td>J None J 1–2 J 3–4 J 5–6 J 7 or more J Depends</td>
</tr>
</tbody>
</table>
### Safety/Weapons/Violence

- **Do you wear a seat belt when you ride in a car, truck, or van?**
  - J Yes
  - J No
  - J Sometimes

- **Do you wear a helmet when you roller blade; skateboard; ride a bike, motorcycle, all-terrain vehicle, mini-bike, scooter; or go snowboarding or skiing? (Circle all activities in which you participate.)**
  - J Yes, for all of the activities circled
  - J No, for all of the activities circled
  - J Sometimes
  - If sometimes, please explain:

- **Have you ever carried a gun or weapon?**
  - J Yes
  - J No

- **Have you ever been in trouble with the law?**
  - J Yes
  - J No

- **Has anyone touched you in a way that made you uncomfortable?**
  - J Yes
  - J No

- **Has anyone ever forced you to have sex?**
  - J Yes
  - J No

- **Has anyone ever hurt you physically or emotionally?**
  - J Yes
  - J No

### For doctor/nurse use

- **Do you or does anyone you live with have a gun, rifle, or other firearm?**
  - J Yes
  - J No

- **Have you ever carried a gun or weapon?**
  - J Yes
  - J No

- **Have you ever been in trouble with the law?**
  - J Yes
  - J No

- **Has anyone touched you in a way that made you uncomfortable?**
  - J Yes
  - J No

- **Has anyone ever forced you to have sex?**
  - J Yes
  - J No

- **Has anyone ever hurt you physically or emotionally?**
  - J Yes
  - J No

### Relationships

- **Are you going out with anyone?**
  - J Yes
  - J No

- **Who do you find yourself attracted to sexually?**
  - J Boys
  - J Girls
  - J Both

- **Do you ever participate in sexual activities, such as touching or oral or anal sex?**
  - J Yes
  - J No

- **If yes, do you use anything to prevent disease?**
  - J Yes
  - J No
  - J Sometimes
  - If yes, what do you use?

- **Have you ever had sex with anyone? If yes, answer the questions in this section below.**
  - J Yes
  - J No

  - If no, do you plan to in the next year? When done answering this question, go to the section "Tobacco, Alcohol, and Drugs."

- **How many sexual partners have you had in the past 3 months?**
  - Over past 3 months:
  - Total:

- **How old were you the first time you had sex (intercourse)?**
  - Age:

- **Have you ever had sex with a person of your same sex?**
  - J Yes
  - J No

- **Do you use anything to prevent pregnancy?**
  - J Yes
  - J No
  - J Sometimes
  - If yes, what do you use?

- **How often do you and your partner(s) use a condom when you have sex?**
  - J Always
  - J Sometimes
  - J Never

- **Have you ever had sex for money or drugs?**
  - J Yes
  - J No

- **Are you worried about your parents knowing that you are having sex?**
  - J Yes
  - J No

### Tobacco, Alcohol, and Drugs

- **Have you or your close friends ever smoked cigarettes or cigars, used snuff, or chewed tobacco?**
  - J Yes, I have J No, I have not
  - J Yes, friends have J No, friends have not
  - J Not sure about friends

- **Have you or your close friends ever gotten drunk on wine, beer, or alcohol?**
  - J Yes, I have J No, I have not
  - J Yes, friends have J No, friends have not
  - J Not sure about friends

- **How much alcohol do you drink at one time?**
  - J Do not drink
  - J 1–2 drinks
  - J 3 or more

- **Do you ever have more than three drinks per occasion?**
  - J Do not drink
  - J Yes

- **In the last year, have you been in a car or other motor vehicle when the driver is drunk or has been drinking alcohol or using drugs? (This includes when you were the driver as well as other people.)**
  - J Yes

- **Would you call your parent(s) or guardian(s) for a ride if you needed to because the person who was supposed to drive you home had been drinking? (This includes when you were the driver as well as other people.)**
  - J Yes
  - J No
  - J Not sure

- **Have you or your close friends ever used marijuana or other drugs (cocaine, heroin, meth, or ecstasy) or sniffed inhalants (glue, gasoline, or solvents)?**
  - J Yes, I have J No, I have not
  - J Yes, friends have J No, friends have not
  - J Not sure

- **Have you ever used a prescription drug to get high?**
  - J Yes
  - J No
  - J Not sure
Have you ever used alcohol or drugs so much that you could not remember what happened (had a blackout)?
| J Do not use drugs or alcohol | J Yes J No |

Have you ever missed work or school because of using alcohol or drugs?
| J Do not use drugs or alcohol | J Yes J No |

Emotions
Do you have more happy days or unhappy days?
| J Happy J Unhappy |

Have you ever seriously thought about hurting yourself?
| J Yes J No |

Do you get nervous or anxious more than other people do?
| J Yes J No |

During the past year, have you had any major good or bad changes in your life (death of someone close, loss of a pet, birth, graduation, moving, change of school, ending or starting a close friendship or romantic relationship)?
| J Good J Bad J No changes |
| J Some good, some bad |

Tell me something good about yourself.

What would you like to discuss with our nurses and doctors today?

Source: American Medical Association, Copyright 1998.