



Confidential Health History (14+)

Name: _____ DOB: _____ MR#: _____ Date of Service: _____

Parents: Please allow your teen to fill this out confidentially. **Patients:** Your doctor asks the following questions during all adolescent check-ups. This questionnaire helps us spend more time talking about areas that are important for you. Please answer honestly. If you're unsure about the answer, leave it blank and we can talk about it. Unless there is a threat to your health or someone else's, all the information you give us here is confidential, even to your parents. Let us know if you have questions!

You & Your Home

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|---|------------------------------|------------------------------|
| 1. Do you feel safe in your home? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Does anyone in your home/family have problems with drugs or alcohol? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 3. Have you ever run away from home? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 4. Are there guns in your home? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 5. Do things happen in your home that bother you a lot? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

You & Your Health

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|--|------------------------------|------------------------------|------------------------------|------------------------------------|
| 1. How many servings of fruits and vegetables do you eat on most days? | <input type="checkbox"/> 0 | <input type="checkbox"/> 1-2 | <input type="checkbox"/> 3-4 | <input type="checkbox"/> 5 or more |
| 2. Do you drink caffeinated beverages (coffee, soda, energy drinks like Monster or Rockstar)? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | |
| 3. How many hours of exercise do you get per week? | <input type="checkbox"/> 0-1 | <input type="checkbox"/> 2-4 | <input type="checkbox"/> 5-6 | <input type="checkbox"/> 7 or more |
| 4. Have you ever passed out during exercise? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | |
| 5. Do you have trouble sleeping? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | |
| 6. Are you happy with the appearance of your body? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |
| 7. Is weight a problem for you? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | |
| 8. Have you ever tried to control your weight by throwing up, using laxatives, restricting what you eat, exercising more, or taking any pills or special drinks? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | |
| 9. Do you wear sunscreen regularly? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |
| 10. Have you ever used supplements or drugs to try to improve athletic performance, change your body's appearance, lose weight, or gain muscle? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | |
| 11. Have you ever tried cigarettes, chew, cigars, pipes, e-cigarettes, hookah, or vaping? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | |
| 12. Do you know that shaving body hair (face, chest, back, legs, pubic) increases risk of skin infections? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |

You & Your Activities

1. What do you do after school? _____

2. How many hours per day do you spend in front of a screen (TV, DVD, video games, texting, computer)? _____

You & School

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|---|------------------------------|------------------------------|
| 1. Are you satisfied with your grades in school? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Are you failing any classes? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 3. Have you ever been kicked out or suspended? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 4. Have you ever been bullied at home, school, or online? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
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You & Your Safety

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| 1. Do you wear a seatbelt every time you get in a car? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Do you wear a helmet every time you ride a bike, ATV, motorcycle, ski/snowboard, or skateboard? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Has anyone touched you in a way that made you feel uncomfortable or afraid? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
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You & Your Body

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|--|---|----------------------------------|--|-------------------------------|-------------------------------------|
| 1. How would you describe your gender? | <input type="checkbox"/> Male | <input type="checkbox"/> Female | <input type="checkbox"/> Other | | |
| 2. What would you say your sexual preference is? | <input type="checkbox"/> Opposite sex | <input type="checkbox"/> Unsure | <input type="checkbox"/> Same sex | <input type="checkbox"/> None | <input type="checkbox"/> Both sexes |
| 3. Have you had sex or any kind of sexual encounters (vaginal sex, oral sex, anal sex)? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | | |
| a. If yes, do your parents know? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |
| b. If yes, have you ever had unprotected sex? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | | |
| c. If yes, what birth control do you use? | <input type="checkbox"/> None | <input type="checkbox"/> Condoms | <input type="checkbox"/> Female birth control (choose type): | | |
| | <input type="checkbox"/> Pills/ring/patch | <input type="checkbox"/> IUD | <input type="checkbox"/> NEXPLANON®/implant | | |
| | <input type="checkbox"/> Morning after pill | <input type="checkbox"/> Shot | | | |
| d. If yes, have you ever had or are you worried you might have a sexually-transmitted infection? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | | |
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You & Your Health Information

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|---|------------------------------|-----------------------------|
| 1. Do you know what it means to sign the MyHealth Proxy form? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Do you want Metro Peds to have your cell phone number? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <i>If yes, what is it?</i> _____ | | |