Metropolitan Pediatrics, L.L.C.

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

1.	Do you feel safe in your home?	❑ Yes	❑ No
2.	Does anyone in your home/family have problems with drugs or alcohol?	❑ No	❑ Yes
3.	Have you ever run away from home?	❑ No	❑ Yes
4.	Do things happen in your home that bother you a lot?	❑ No	❑ Yes
5.	Are there guns in your home?	❑ No	❑ Yes
	a. If yes, is the gun(s) stored in a locked area?	❑ Yes	❑ No
	b. If yes, is the ammunition stored and locked separately from the gun(s)?	❑ Yes	❑ No

You & Your Health

1.	How many servings of fruits and vegetables do you eat on most days?	❑ 0	❑ 1-2	❑ 3-4	❑ 5 or more
2.	Do you drink caffeinated beverages (coffee, soda, energy drinks like Monster or Rockstar)?	❑ No		❑ Yes	
3.	How many hours of exercise do you get per week?	❑ 0-1	❑ 2-4	❑ 5-6	❑ 7 or more
4.	Have you ever passed out during exercise?	❑ No		❑ Yes	
5.	Do you have trouble sleeping?	❑ No		❑ Yes	
6.	Are you happy with the appearance of your body?	❑ Yes		❑ No	
7.	Is weight a problem for you?	❑ No		❑ 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?	❑ No		❑ Yes	
9.	Do you wear sunscreen regularly?	❑ Yes		❑ 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?	❑ No		❑ Yes	
11.	Have you ever tried cigarettes, chew, cigars, pipes, e-cigarettes, hookah, or vaping?	❑ No		❑ Yes	

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)? _____

MORE QUESTIONS ON THE BACK SIDE ⇨

You & School

1.	Are you satisfied with your grades in school?	❑ Yes	❑ No
2.	Are you failing any classes?	❑ No	❑ Yes
3.	Have you ever been kicked out or suspended?	❑ No	❑ Yes
4.	Have you ever been bullied at home, school, or online?	❑ No	❑ Yes

You & Your Safety

1.	Do you wear a seatbelt every time you get in a car?	❑ Yes	❑ No
2.	Do you wear a helmet every time you ride a bike, ATV, motorcycle, ski/snowboard, or skateboard?	❑ Yes	❑ No
3.	Has anyone touched you in a way that made you feel uncomfortable or afraid?	❑ No	❑ Yes
4.	Are you now or have you been in a relationship where your partner was controlling, or made you feel unsafe?	❑ No	❑ Yes

You & Your Body

1.	How would you describe your gender?	❑ Male	❑ Female ❑ Other
2.	What would you say your sexual preference is?	❑ Opposite sex ❑ Same sex ❑ Both sexes	❑ Unsure ❑ None
3.	Have you had sex or any kind of sexual encounters (vaginal sex, oral sex, anal sex)?	❑ No	❑ Yes
	a. If yes, do your parents know?	❑ Yes	❑ No
	b. If yes, how many partners have you had in the past year? →	Answer:	
	c. If yes, have you ever had unprotected sex?	❑ No	❑ Yes
	d. If yes, what birth control do you use?	❑ None ❑ Condoms ❑ Female birth control (choose type): ❑ Pills/ring/patch ❑ IUD ❑ NEXPLANON®/implant ❑ Morning after pill ❑ Shot	
	e. If yes, have you ever had or are you worried you might have a sexually-transmitted infection?	❑ No	❑ Yes
4.	Would you or your partner like to become pregnant in the next year?	❑ No	❑ Yes

You & Your Health Information

1.	Do you know what it means to sign the MyHealth Proxy form?	❑ Yes	❑ No
2.	What is your personal cell phone number? → (This is so your provider can call you directly, if needed.)	Answer:	