Metropolitan Pediatrics, L.L.C.

Confidential Health History (ages 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 checkups. 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

6. How many servings of fruits and vegetables do you eat on most days? ❑ 0 ❑ 1-2 ❑ 3-4 ❑ 5+
7. Do you drink caffeinated beverages (coffee, soda, energy drinks like Monster or Rockstar)? ❑ No ❑ Yes
8. How many hours of exercise do you get per week? ❑ 0-1 ❑ 2-4 ❑ 5-6 ❑ 7+
9. Have you ever passed out during exercise? ❑ No ❑ Yes
10. Do you have trouble sleeping? ❑ No ❑ Yes
11. Are you happy with the appearance of your body? ❑ Yes ❑ No
12. Is weight a problem for you? ❑ No ❑ Yes
13. 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
14. Do you wear sunscreen regularly? ❑ Yes ❑ No
15. 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
16. Have you ever tried cigarettes, chew, cigars, pipes, e-cigarettes, hookah, or vaping? ❑ No ❑ Yes

MORE QUESTIONS ON BACK ▸

You & Your Activities

17. What do you do after school? _____

_____

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

You & School

19. Are you satisfied with your grades in school? ..... ❑ Yes ❑ No
20. Are you failing any classes? ..... ❑ No ❑ Yes
21. Have you ever been kicked out or suspended? ..... ❑ No ❑ Yes
22. Have you ever been bullied at home, school, or online? ..... ❑ No ❑ Yes

You & Your Safety

23. Do you wear a seatbelt every time you get in a car? ..... ❑ Yes ❑ No
24. Do you wear a helmet every time you ride a bike, ATV, motorcycle, ski/snowboard, or skateboard? ..... ❑ Yes ❑ No
25. Has anyone touched you in a way that made you feel uncomfortable or afraid? ..... ❑ No ❑ Yes
26. 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

27. How would you describe your gender? _____
28. What would you say your sexual orientation is? _____
29. 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? _____
    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):
    ❑ 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
30. Would you or your partner like to become pregnant in the next year? ..... ❑ No ❑ Yes

You & Your Health Information

31. Do you know what it means to sign the MyHealth Proxy form? ..... ❑ Yes ❑ No
32. What is your personal cell phone number if your provider needs to call you directly? _____