Metropolitan Pediatrics

Health History (Ages 11-13)

Name: _____ Birthday: _____ Visit Date: _____

Parents: Please allow your preteen or teen to fill this out confidentially.

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

17. Do you know that shaving body hair (face, chest, back, legs, pubic) increases risk of skin infections? ☐ Yes ☐ No

You & Your Activities

18. What do you do after school? _____

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

You & School

20. Are you satisfied with your grades in school? ☐ Yes ☐ No

21. Are you failing any classes? ☐ No ☐ Yes

22. Have you ever been kicked out or suspended? ☐ No ☐ Yes

23. Have you ever been bullied at home, school, or online? ☐ No ☐ Yes

You & Your Safety

24. Do you wear a seatbelt every time you get in a car? ☐ Yes ☐ No

25. Do you wear a helmet every time you ride a bike, ATV, motorcycle, ski/snowboard, or skateboard? ☐ Yes ☐ No

26. Has anyone touched you in a way that made you feel uncomfortable or afraid? ☐ No ☐ Yes

You & Your Body

27. How would you describe your gender? _____