Mālama I Ke Ola
HEALTH CENTER

CONFIDENTIAL ADOLESCENT QUESTIONNAIRE

Instructions: We are interested in your health. Please fill out this form and return it to us.

PREFERRED NAME: _____**DATE:** _____ Age: _____

Birthdate: _____ Pronouns: _____

Why are you seeing the doctor?_____

Have you ever been hospitalized? _____If yes, how old were you? _____

And why? _____

Date of last dental exam? _____Any problems? _____

CIRCLE any of the following which have bothered you in the past 3 months:

GENERAL: Trouble sleeping Nightmares Allergies Excessive sweating Reaction to insect bites Weigh too much Weigh too little Sad or depressed	**HEART/RESPIRATORY:** Skipped heartbeats Chest pain Shortness of breath Wheezing Asthma Hay fever Coughed up blood Pneumonia Bronchitis Allergies	**SEXUAL/URINARY:** Vaginal discharge Blood in urine Painful urination Bedwetting Bladder control problems Sexually transmitted disease (VD, Chlamydia, sores on Vagina.)
SKIN: Eczema Acne Skin rash Hives Jaundice (yellow color)	**HEAD/EYES:** Headaches Dizzy spells Fainting Seizures/convulsions Head/brain injury Blurred vision	**EARS/NOSE/THROAT:** Earaches Ringing in ears Hearing loss Nosebleeds Frequent colds Frequent sore throats
GASTORINTESTINAL: Stomach aches Constipation Diarrhea Nausea Bleeding from rectum Indigestion	**BONE/JOINT:** Fractures Sprains Athletic injuries Backaches Painful bones or joints	

Do you have any questions about the following? If yes, please circle all that apply.

SEX	DRUGS	ALCOHOL
BIRTH CONTROL	PREGNANCY	DATING
GENDER IDENTITY	SEXUALITY	

Please list any problems you want to talk about with the doctor:

_____

CIRCLE YES OR NO:

Are you taking any medications?	Yes No
Are taking any vitamins?	Yes No
Are you using any type of birth control?	Yes No
Do you think your body isn't changing or growing as it should?	Yes No
Do you have a hard time making or keeping friends?	Yes No
Do you drive a car or motorcycle?	Yes No
Did you take driver's education?	Yes No
Do you often drive without wearing your seatbelt?	Yes No
Can you swim?	Yes No
Did you take driver's education?	Yes No

If you exercise regularly, what do you do? _____

FOR GIRLS:

Have you started your period?	Yes No

If yes, at what age? _____

Do you use:? PADS TAMPONS

Do you have any problems with cramps or irregular periods?	Yes No
Do you have any questions about your period?	Yes No
Do you have any itchy or bad smelling vaginal discharge?	Yes No
Have you ever been pregnant?	Yes No
Have you been taught how to do a breast self-exam?	Yes No
Do you think that you can't get pregnant?	Yes No

FOR BOYS:

Have you ever had a discharge (leaking) from your penis?	Yes No
Do you worry you might get someone pregnant?	Yes No
Do you use condoms?	Yes No

The growth of breast in boys is a normal, but temporary event.

Has this ever been a concern to you?	Yes No
Have you fathered any children?	Yes No

If yes, how many? _____

Have you been shown how to do a self-testicular exam?	Yes No
Do you have any pain in your testicles or groin area?	Yes No
Are you worried that you might not be fertile and can't father any children?	Yes No

SCHOOL AND WORK

Grade: _____
Are worried about school? _____
How many days of school did you miss?
This year? _____Last Year? _____
What class do you like:
The most? _____
The least? _____
What class are you doing:
The best in? _____
The worst in? _____
Do you have plans for after you
Graduate: Yes No
If yes, what are they? _____
Do you work? _____If yes, where
Special interests/hobbies/sports:
Responsibilities at home: