Guidelines for Adolescent Preventive Services

Middle-Older Adolescent Questionnaire

Confidential (Your answers will not be given out.) Chart # _____

Name _____ Date _____
Last First Middle Initial

Date of Birth _____ Grade in School_____ Year in college_____ Sex: Male Female Age _____

Address_____ City _____ Zip _____

Phone number where you can be reached _____ Pager/beeper number_____

What languages are spoken where you live? _____Race _____

Medical History

1. Why did you come to the clinic/office today? _____
2. Do you have any health problems? ☐ Yes ☐ No Problem(s) _____
3. Did you have any health problems in the past 12 months? ☐ Yes ☐ No Problem(s) _____
4. Are you taking any medicine now? ☐ Yes ☐ No Name of medicine _____

For Girls

5. Date when last period started_____ Are your periods regular (monthly)? ..... ☐ No ☐ Yes
Month Date
6. Have you had a miscarriage, an abortion, or live birth in the past 12 months? ..... ☐ Yes ☐ No

Specific Health Issues

7. Please check whether you have questions or are worried about any of the following:

- ☐ Height/weight
- ☐ Blood pressure
- ☐ Diet/food/appetite
- ☐ Future plans/job
- ☐ Skin (rash, acne)
- ☐ Headaches/migraines
- ☐ Dizziness/fainting
- ☐ Eyes/vision
- ☐ Ears/hearing/ear aches
- ☐ Nose
- ☐ Lots of colds
- ☐ Mouth/teeth/breath
- ☐ Neck/back
- ☐ Chest pain/trouble breathing
- ☐ Coughing/wheezing
- ☐ Breasts
- ☐ Heart
- ☐ Stomach ache
- ☐ Nausea/vomiting
- ☐ Diarrhea/constipation
- ☐ Muscle or joint pain in arms/legs
- ☐ Frequent or painful urination
- ☐ Discharge from penis or vagina
- ☐ Wetting the bed
- ☐ Sexual organs/genitals
- ☐ Menstruation/periods
- ☐ Wet dreams
- ☐ Physical or sexual abuse
- ☐ Masturbation
- ☐ HIV/AIDS
- ☐ Trouble sleeping
- ☐ Feeling tired a lot
- ☐ Cancer
- ☐ Dying
- ☐ Sad or crying a lot
- ☐ Stress
- ☐ Anger/temper
- ☐ Violence/personal safety
- ☐ Other (explain)

_____

_____

Health Profile

These questions will help us get to know you better. Choose the answer that best describes what you feel or do. Your answers will be seen only by your health care provider and his/her assistant.

Eating/Weight

8. Are you satisfied with your eating habits? ..... ☐ No ☐ Yes
9. Do you ever eat in secret? ..... ☐ Yes ☐ No
10. Do you spend a lot of time thinking about ways to be thin? ..... ☐ Yes ☐ No
11. In the past year, have you tried to lose weight or control your weight by vomiting, taking diet pills or laxatives, or starving yourself? ..... ☐ Yes ☐ No
12. Do you exercise or participate in sport activities that make you sweat and breathe hard for 20 minutes or more at a time at least three or more times during the week? ..... ☐ No ☐ Yes

School

13. Are your grades this year worse than last year? ..... ☐ Yes ☐ No ☐ Not in school
14. Have you either been told you have a learning problem or do you think you have a learning problem? ..... ☐ Yes ☐ No
15. Have you been suspended from school this year? ..... ☐ Yes ☐ No ☐ Not in school

Friends & Family

16. Do you have at least one friend who you really like and feel you can talk to? ..... ☐ No ☐ Yes
17. Do you think that your parent(s) or guardian(s) *usually* listen to you and take your feelings seriously? ..... ☐ No ☐ Yes
18. Have you ever thought seriously about running away from home? ..... ☐ Yes ☐ No ☐ Not sure

Turn page

Weapons/Violence/Safety

19. Do you or anyone you live with have a gun, rifle, or other firearm? ☐ Yes ☐ No ☐ Not sure
20. In the past year, have you carried a gun, knife, club, or other weapon for protection? ☐ Yes ☐ No
21. Have you been in a physical fight during the *past 3 months*? ☐ Yes ☐ No
22. Have you ever been in trouble with the law? ☐ Yes ☐ No
23. Are you worried about violence or your safety? ☐ Yes ☐ No ☐ Not sure
24. Do you usually wear a helmet when you rollerblade, skateboard, ride a bicycle , motorcycle, minibike, or ride in an all-terrain vehicle (ATV)? ☐ No ☐ Yes
25. Do you usually wear a seat belt when you ride in or drive a car, truck, or van? ☐ No ☐ Yes

Tobacco

26. Do you ever smoke cigarettes/cigars, use snuff or chew tobacco? ☐ Yes ☐ No
26. Do any of your close friends ever smoke cigarettes/cigars, use snuff or chew tobacco? ☐ Yes ☐ No
28. Does anyone you live with smoke cigarettes/cigars, use snuff or chew tobacco? ☐ Yes ☐ No

Alcohol

29. In the past month, did you get drunk or very high on beer, wine, or other alcohol? ☐ Yes ☐ No
30. In the past month, did any of your close friends get drunk or very high on beer, wine, or other alcohol? ☐ Yes ☐ No
31. Have you ever been criticized or gotten into trouble because of drinking? ☐ Yes ☐ No ☐ Not sure
32. In the past year have you used alcohol and then driven a car/truck/van/motorcycle? ☐ Yes ☐ No ☐ Does not apply
33. In the past year, have you been in a car or other motor vehicle when the driver has been drinking alcohol or using drugs? ☐ Yes ☐ No
34. Does anyone in your family drink or take drugs so much that it worries you? ☐ Yes ☐ No

Drugs

35. Do you ever use marijuana or other drugs, or sniff inhalants? ☐ Yes ☐ No ☐ Not sure
36. Do any of your close friends ever use marijuana or other drugs, or sniff inhalants? ☐ Yes ☐ No ☐ Not sure
37. Do you ever use non-prescription drugs to get to sleep, stay awake, calm down, or get high? (These drugs can be bought at a store without a doctor's prescription.) ☐ Yes ☐ No
38. Have you ever used steroid pills or shots without a doctor telling you to? ☐ Yes ☐ No ☐ Not sure

Development

39. Do you have any concerns or questions about the size or shape of your body, or your physical appearance? ☐ Yes ☐ No ☐ Not sure
40. Do you think you may be gay, lesbian, or bisexual? ☐ Yes ☐ No ☐ Not sure
41. Have you ever had sexual intercourse? (How old were you the first time?_____) ☐ Yes ☐ No ☐ Not sure
42. Are you using a method to prevent pregnancy? (Which:_____) ☐ No ☐ Yes ☐ Not active
43. Do you and your partner(s) *always* use condoms when you have sex? ☐ No ☐ Yes ☐ Not active
44. Have any of your close friends ever had sexual intercourse? ☐ Yes ☐ No ☐ Not sure
45. Have you ever been told by a doctor or nurse that you had a sexually transmitted infection or disease? ☐ Yes ☐ No ☐ Not sure
46. Have you ever been pregnant or gotten someone pregnant? ☐ Yes ☐ No ☐ Not sure
47. Would you like to receive information or supplies to prevent pregnancy or sexually transmitted infections? ☐ Yes ☐ No ☐ Not sure
48. Would you like to know how to avoid getting HIV/AIDS? ☐ Yes ☐ No ☐ Not sure
49. Have you pierced your body (not including ears) or gotten a tattoo? ☐ Yes ☐ No ☐ Thinking about it

Emotions

50. Have you had fun during the past two weeks? ☐ No ☐ Yes
51. During the past few weeks, have you *often* felt sad or down or as though you have nothing to look forward to? ☐ Yes ☐ No
52. Have you ever *seriously* thought about killing yourself, made a plan or actually tried to kill yourself? ☐ Yes ☐ No
53. Have you ever been physically, sexually, or emotionally abused? ☐ Yes ☐ No ☐ Not sure
54. When you get angry, do you do violent things? ☐ Yes ☐ No
55. Would you like to get counseling about something you have on your mind? ☐ Yes ☐ No ☐ Not sure

Special Circumstances

56. In the past year, have you been around someone with tuberculosis (TB)? ☐ Yes ☐ No ☐ Not sure
57. In the past year, have you stayed overnight in a homeless shelter, jail, or detention center? ☐ Yes ☐ No
58. Have you ever lived in foster care or a group home? ☐ Yes ☐ No

Self

59. What four words best describe you? _____
60. If you could change one thing about your life or yourself, what would it be? _____

_____

61. What do you want to talk about today? _____

97-892:1.2M:11/97

Nataloni Pediatrics, P.C.

Pre-Participation Physical Evaluation

Patient's Name: _____ Date of Birth: _____ Age: _____

The following questions should be completed by student or parent. Please explain "yes" answeres where indicated. Circle questions you don't know answers to.

		Yes	No
1.	Have you had a medical illness or injury since your last check-up or sports physical? If yes, please explain: _____	☐	☐
2.	Do you have an ongoing illness? If yes, please explain: _____	☐	☐
3.	Have you ever been hospitalized overnight? If yes, please explain: _____	☐	☐
4.	Have you ever had surgery? If yes, please explain: _____	☐	☐
5.	Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills, or using an inhaler? If yes, please explain: _____	☐	☐
6.	Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your Performance? If yes, please explain: _____	☐	☐
7.	Do you have any allergies (for example: to pollen, medicine, food or stinging insects)? If yes, please explain: _____	☐	☐
8.	Have you ever had a rash or hives develop during or after exercise? If yes, please explain: _____	☐	☐
9.	Have you ever passed out during or after exercise? If yes, please explain: _____	☐	☐
10.	Have you ever been dizzy during or after exercise? If yes, please explain: _____	☐	☐
11.	Have you ever had chest pain during or after exercise? If yes, please explain: _____	☐	☐
12.	Do you get tires more quickly than your friends do during exercise? If yes, please explain: _____	☐	☐
13.	Have you ever had racing of your heart or skipped heartbeats? If yes, please explain: _____	☐	☐
14.	Have you ever had high blood pressure or high cholesterol? If yes, please explain: _____	☐	☐
15.	Have you ever been told you have a heart murmur? If yes, please explain: _____	☐	☐
16.	Has any family member or relative died of heart problems or sudden death before age 50? If yes, please explain: _____	☐	☐
17.	Have you had a severe viral infection (for example: myocarditis or mononucleosis) within the last month? If yes, please explain: _____	☐	☐
18.	Has a physician ever denied or restricted your participation in sports for any heart problems? If yes, please explain: _____	☐	☐
19.	Do you have any current skin problems (for example: itching, rashes, acne, warts, fungus or blisters)? If yes, please explain: _____	☐	☐
20.	Have you ever had a head injury or concussion? If yes, please explain: _____	☐	☐
21.	Have you ever been knocked out, become unconscious or lost your memory? If yes, please explain: _____	☐	☐
22.	Have you ever had a seizure? If yes, please explain: _____	☐	☐

	Yes	No
23. Do you have frequent or severe headaches?	☐	☐
If yes, please explain: _____		
24. Have you ever had numbness or tingling in your arms, hands, legs or feet?	☐	☐
If yes, please explain: _____		
25. Have you ever had a stinger, burner or pinched nerve?	☐	☐
If yes, please explain: _____		
26. Have you ever become ill from exercising in the heat?	☐	☐
If yes, please explain: _____		
27. Do you cough, wheeze or have trouble breathing during or after activity?	☐	☐
If yes, please explain: _____		
28. Do you have asthma?	☐	☐
If yes, please explain: _____		
29. Do you have seasonal allergies that require medical treatment?	☐	☐
If yes, please explain: _____		
30. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position, (for example, knee brace, special neck roll, foot orthotics, retainer for your teeth, hearing aid)?	☐	☐
If yes, please explain: _____		
31. Have you had any problems with your eyes or vision?	☐	☐
If yes, please explain: _____		
32. Do you wear glasses, contacts or protective eyewear?	☐	☐
If yes, please explain: _____		
33. Have you ever had a sprain, strain or swelling after injury?	☐	☐
If yes, please explain: _____		
34. Have you broken or fractured any bones or dislocated any joints?	☐	☐
If yes, please explain: _____		
35. Have you had any other problems with pain or swelling in muscles, tendons, bones or joints?	☐	☐
If yes, check appropriate blank and explain in the space provided:		
___Head ___Elbow ___Hip ___Neck ___Forearm ___Thigh ___Back ___Wrist ___Knee		
___Chest ___Hand ___Shin/Calf ___Shoulder ___Finger ___Ankle ___Upper Arm ___Foot		
If yes, please explain: _____		
36. Do you want to weigh more or less than you do now?	☐	☐
If yes, please explain: _____		
37. Do you lose weight regularly to meet weight requirements for your sport?	☐	☐
If yes, please explain: _____		
38. Do you feel stressed out?	☐	☐
If yes, please explain: _____		

39. Record the dates of your most recent immunizations (shots) for:

Tetanus: _____

Measles: _____

Hepatitis B: _____

Chickenpox: _____

FEMALES ONLY – Optional –

40. When was your first menstrual period?

_____

41. When was your most recent menstrual period?

_____

42. How much time do you usually have from the start of one period to the start of another?

_____

43. How many periods have you had in the last year?

_____

44. What was the longest time between periods in the last year?

_____

Signature of parent/guardian: _____ Date: _____

A Survey From Your Healthcare Provider

Name	Date	ID

Please mark under the heading that best fits you or circle yes or no	Never 0	Sometimes 1	Often 2
1. Complain of aches or pains			
2. Spend more time alone			
3. Tire easily, little energy			
4. Fidgety, unable to sit still			
5. Have trouble with teacher			
6. Less interested in school			
7. Act as if driven by motor			
8. Daydream too much			
9. Distract easily			
10. Are afraid of new situations			
11. Feel sad, unhappy			
12. Are irritable, angry			
13. Feel hopeless			
14. Have trouble concentrating			
15. Less interested in friends			
16. Fight with other children			
17. Absent from school			
18. School grades dropping			
19. Down on yourself			
20. Visit doctor with doctor finding nothing wrong			
21. Have trouble sleeping			
22. Worry a lot			
23. Want to be with parent more than before			
24. Feel that you are bad			
25. Take unnecessary risks			
26. Get hurt frequently			
27. Seem to be having less fun			
28. Act younger than children your age			
29. Do not listen to rules			
30. Do not show feelings			
31. Do not understand other people's feelings			
32. Tease others			
33. Blame others for your troubles			
34. Take things that do not belong to you			
35. Refuse to share			
36. During the past three months, have you thought of killing yourself?		Yes	No
37. Have you ever tried to kill yourself?		Yes	No

FOR OFFICE USE ONLY

Cutoff Scores for Interpretation: I ≥ 5 | E ≥ 7 | A ≥ 7

TS _____

Q 36 or Q 37=Y | TS ≥ 30

Plan for follow-up

❑ Annual Screening ❑ Return visit w/ PCP ❑ Referred to counselor ❑ Parent declined ❑ Already in treatment ❑ Referred to other professional

Source: Pediatric Symptom Checklist – Youth Report (PSC-Y)

nataloni
Pediatrics P.C.

701 RT. 25A Suite B3
Mt. Sinai, NY 11766
Phone: 631-476-7676
Fax: 631-476-7675

ADOLESCENT CONFIDENTIALITY STATEMENT

Parent Information for Pediatric Visits
Ages 12-21 years

As children and adolescents mature and become more independent, both physiologically and socially, their physical health may be jeopardized. Risk-taking behaviors are increasingly observed in this age group.

We plan to discuss these issues with your child and offer non-judgmental support and advice. Confidentiality is promised to the adolescents as part of our working relationship. We do, however, strongly encourage them to discuss these issues openly with their families, and we will inform you if your adolescent poses a serious risk to him/herself or others.

Please advise us of any specific concerns you have regarding risk-taking behaviors or the emotional health of your adolescent.

Please sign indicating your understanding of the (above) information.

Adolescent's Name

Your relationship to above

Signature:_____

Date:

Guidelines for Adolescent Preventive Services
Parent/Guardian Questionnaire

Confidential (Your answers will not be given out.)

Date _____

Adolescent's name _____ Adolescent's birthday _____ Age _____

Parent/Guardian name _____ Relationship to adolescent _____

Your phone number: Home _____ Work _____

Adolescent Health History

1. Is your adolescent allergic to any medicines?
   ☐ Yes ☐ No If yes, what medicines? _____

2. Please provide the following information about medicines your adolescent is taking.

Name of medicine	Reason taken	How long taken
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Has your adolescent ever been hospitalized overnight?
   ☐ Yes ☐ No If yes, give the age at time of hospitalization and describe the problem.

Age	Problem
_____	_____
_____	_____

4. Has your adolescent ever had any serious injuries?
   ☐ Yes ☐ No If yes, please explain. _____

5. Have there been any changes in your adolescent's health during the past 12 months?
   ☐ Yes ☐ No If yes, please explain. _____

6. Please check (✓) whether your adolescent ever had any of the following health problems:
   If yes, at what age did the problem start:

	Yes	No	Age		Yes	No	Age
ADHD/learning disability	☐	☐	_____	Headaches/migraines	☐	☐	_____
Allergies/hayfever	☐	☐	_____	Low iron in blood (anemia)	☐	☐	_____
Asthma	☐	☐	_____	Pneumonia	☐	☐	_____
Bladder or kidney infections	☐	☐	_____	Rheumatic fever or heart disease	☐	☐	_____
Blood disorders/sickle cell anemia	☐	☐	_____	Scoliosis (curved spine)	☐	☐	_____
Cancer	☐	☐	_____	Seizures/epilepsy	☐	☐	_____
Chicken pox	☐	☐	_____	Severe acne	☐	☐	_____
Depression	☐	☐	_____	Stomach problems	☐	☐	_____
Diabetes	☐	☐	_____	Tuberculosis (TB)/lung disease	☐	☐	_____
Eating disorder	☐	☐	_____	Mononucleosis (mono)	☐	☐	_____
Emotional disorder	☐	☐	_____	Other: _____	☐	☐	_____
Hepatitis (liver disease)	☐	☐	_____				

7. Does this office or clinic have an up-to-date record of your adolescent's immunizations (record of "shots")?
   ☐ Yes ☐ No ☐ Not sure

Family History

8. Some health problems are passed from one generation to the next. Have you or any of your adolescent's *blood* relatives (parents, grandparents, aunts, uncles, brothers or sisters), living or deceased, had any of the following problems? If the answer is "Yes," please state the age of the person when the problem occurred and his or her relationship to your adolescent.

	Yes	No	Unsure	Age at Onset	Relationship
Allergies/asthma	☐	☐	☐	_____	_____
Arthritis	☐	☐	☐	_____	_____
Birth defects	☐	☐	☐	_____	_____
Blood disorders/sickle cell anemia	☐	☐	☐	_____	_____

	Yes	No	Unsure	Age at Onset	Relationship
Cancer (type_____)	☐	☐	☐	_____	_____
Depression	☐	☐	☐	_____	_____
Diabetes	☐	☐	☐	_____	_____
Drinking problem/alcoholism	☐	☐	☐	_____	_____
Drug addiction	☐	☐	☐	_____	_____
Endocrine/gland disease	☐	☐	☐	_____	_____
Heart attack or stroke *before* age 55	☐	☐	☐	_____	_____
Heart attack or stroke *after* age 55	☐	☐	☐	_____	_____
High blood pressure	☐	☐	☐	_____	_____
High cholesterol	☐	☐	☐	_____	_____
Kidney disease	☐	☐	☐	_____	_____
Learning disability	☐	☐	☐	_____	_____
Liver disease	☐	☐	☐	_____	_____
Mental health	☐	☐	☐	_____	_____
Mental retardation	☐	☐	☐	_____	_____
Migraine headaches	☐	☐	☐	_____	_____
Obesity	☐	☐	☐	_____	_____
Seiures/epilepsy	☐	☐	☐	_____	_____
Smoking	☐	☐	☐	_____	_____
Tuberculosis/lung disease	☐	☐	☐	_____	_____

9. With whom does the adolescent live most of the time? *(Check all that apply.)*

☐ Both parents in same household
☐ Mother
☐ Father
☐ Other adult relative
☐ Stepmother
☐ Stepfather
☐ Guardian
☐ Brother(s)/ages _____
☐ Sister(s)/ages _____
☐ Other _____
☐ Alone

10. In the past year, have there been any changes in your family? *(Check all that apply.)*

☐ Marriage
☐ Separation
☐ Divorce
☐ Loss of job
☐ Move to a new neighborhood
☐ A new school or college
☐ Births
☐ Serious illness
☐ Deaths
☐ Other _____

Parental / Guardian Concerns

11. Please review the topics listed below. Check(✓) if you have a concern about your adolescent.

	Concern About My Adolescent		Concern About My Adolescent
Physical problems	☐	Guns/weapons	☐
Physical development	☐	School grades/absences/dropout	☐
Weight	☐	Smoking cigarettes/chewing tobacco	☐
Change of appetite	☐	Drug use	☐
Sleep patterns	☐	Alcohol use	☐
Diet/nutrition	☐	Dating/parties	☐
Amount of physical activity	☐	Sexual behavior	☐
Emotional development	☐	Unprotected sex	☐
Relationships with parents and family	☐	HIV/AIDS	☐
Choice of friends	☐	Sexual transmitted diseases (STDs)	☐
Self image or self worth	☐	Pregnancy	☐
Excessive moodiness or rebellion	☐	Sexual identity (heterosexual/homosexual/bisexual)	☐
Depression	☐	Work or job	☐
Lying, stealing, or vandalism	☐	Other: _____	☐
Violence/gangs	☐		

12. What seems to be the greatest challenge for your teen? _____

13. What is it about your teen that makes you proud of him or her? _____

14. Is there something on your mind that you would like to talk about today?

What is it? _____

15. Can we share your answers to Question 13 with your teen? ☐ Yes ☐ No