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### CONFIDENTIAL HEALTH SURVEY (To Be Filled in by Teenager)

**Instructions:** Completion of this form is voluntary. This questionnaire will help us get to know you better. Please answer the following questions and feel free to ask a staff member about items which may be confusing to you.

Patient Name	Date of Birth	Today's Date
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What do you like to be called (nickname)?

Why are you coming to the clinic today?

On a scale from 1 to 10 how would you rate your general health? Worst  1  2  3  4  5  6  7  8  9  10 Excellent

Many teens and young adults have concerns about the following items. Check any box that may apply to you.

- |   |  |
|---|--|
| <input type="checkbox"/> Trouble Sleeping             | <input type="checkbox"/> Privacy   |
| <input type="checkbox"/> Being Tired During the Day   | <input type="checkbox"/> Friends   |
| <input type="checkbox"/> Headaches                    | <input type="checkbox"/> No Friends  |
| <input type="checkbox"/> Stomach Aches                | <input type="checkbox"/> Brothers / Sisters  |
| <input type="checkbox"/> Dizzy / Fainting Spells      | <input type="checkbox"/> Parent / Family   |
| <input type="checkbox"/> Height or Weight             | <input type="checkbox"/> Grades / School   |
| <input type="checkbox"/> Muscle or Joint Pain         | <input type="checkbox"/> Recurrent Dreams or Nightmares                                      |
| <input type="checkbox"/> Vision or Hearing Problems   | <input type="checkbox"/> Fear of Unplanned Pregnancy or Sexually Transmitted Diseases (STDs) |
| <input type="checkbox"/> Skin Problems (Acne, Rashes) | <input type="checkbox"/> Controlling Your Temper   |
| <input type="checkbox"/> Earaches                     | <input type="checkbox"/> Nothing to Do   |
| <input type="checkbox"/> Sore Throats                 | <input type="checkbox"/> Your Future   |
| <input type="checkbox"/> Coughing or Wheezing         | <input type="checkbox"/> Feeling Down or Depressed   |
| <input type="checkbox"/> Vomiting                     | <input type="checkbox"/> A Place to Live   |
| <input type="checkbox"/> Diarrhea                     | <input type="checkbox"/> Family Members Drinking Excess Alcohol                              |
| <input type="checkbox"/> Pain with Urination          | <input type="checkbox"/> Using Drugs   |
| <input type="checkbox"/> Allergies                    |  |
| <input type="checkbox"/> Other, Describe              |  |

Check all the boxes you would like to know more about.

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Menstruation                 | <input type="checkbox"/> AIDS* or HIV** Exposure  | <input type="checkbox"/> Your Sexual Development / Feelings |
| <input type="checkbox"/> Pregnancy or Having Children | <input type="checkbox"/> Teenage Body Changes     | <input type="checkbox"/> Masturbation                       |
| <input type="checkbox"/> Birth Control                | <input type="checkbox"/> Ways to Deal with Stress | <input type="checkbox"/> Drugs / Alcohol                    |
| <input type="checkbox"/> Dating                       | <input type="checkbox"/> Sexual Assault or Abuse  | <input type="checkbox"/> Cancer                             |
| <input type="checkbox"/> STDs                         | <input type="checkbox"/> Physical Abuse           | <input type="checkbox"/> Death and Dying                    |
| <input type="checkbox"/> Other, Describe              |   |   |

Now think about these lifestyle patterns that may affect your health. Are there any you would like to change? If yes, check the appropriate boxes.

- |   |   |
|---|---|
| <input type="checkbox"/> Nutrition or Diet          | <input type="checkbox"/> Drinking Alcohol or Using Drugs              |
| <input type="checkbox"/> Exercise                   | <input type="checkbox"/> Getting Along with Family                    |
| <input type="checkbox"/> Smoking / Chewing Tobacco  | <input type="checkbox"/> Sexuality                                    |
| <input type="checkbox"/> Sleep                      | <input type="checkbox"/> Finding a Job                                |
| <input type="checkbox"/> Your Response to Stress    | <input type="checkbox"/> Communication with Parents and Others        |
| <input type="checkbox"/> School Performance         | <input type="checkbox"/> Use of Seat Belt / Motorcycle / Bike Helmets |
| <input type="checkbox"/> Making and Keeping Friends |   |

\* AIDS = Acquired Immune Deficiency Syndrome.

\*\* HIV = Human Immunodeficiency Virus.