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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"/> Head aches | <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.