# DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN

Division of Medicaid Services

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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      |
| 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.[ ]  Trouble Sleeping [ ]  Privacy[ ]  Being Tired During the Day [ ]  Friends[ ]  Headaches [ ]  No Friends[ ]  Stomach Aches [ ]  Brothers / Sisters[ ]  Dizzy / Fainting Spells [ ]  Parent / Family[ ]  Height or Weight [ ]  Grades / School[ ]  Muscle or Joint Pain [ ]  Recurrent Dreams or Nightmares[ ]  Vision or Hearing Problems [ ]  Fear of Unplanned Pregnancy or Sexually Transmitted Diseases (STDs)[ ]  Skin Problems (Acne, Rashes) [ ]  Controlling Your Temper[ ]  Earaches [ ]  Nothing to Do[ ]  Sore Throats [ ]  Your Future[ ]  Coughing or Wheezing [ ]  Feeling Down or Depressed[ ]  Vomiting [ ]  A Place to Live[ ]  Diarrhea [ ]  Family Members Drinking Excess Alcohol[ ]  Pain with Urination [ ]  Using Drugs[ ]  Allergies[ ]  Other, Describe      |
| Check all the boxes you would like to know more about.[ ]  Menstruation [ ]  AIDS\* or HIV\*\* Exposure [ ]  Your Sexual Development / Feelings[ ]  Pregnancy or Having Children [ ]  Teenage Body Changes [ ]  Masturbation[ ]  Birth Control [ ]  Ways to Deal with Stress [ ]  Drugs / Alcohol[ ]  Dating [ ]  Sexual Assault or Abuse [ ]  Cancer[ ]  STDs [ ]  Physical Abuse [ ]  Death and Dying[ ]  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.[ ]  Nutrition or Diet [ ]  Drinking Alcohol or Using Drugs[ ]  Exercise [ ]  Getting Along with Family[ ]  Smoking / Chewing Tobacco [ ]  Sexuality[ ]  Sleep [ ]  Finding a Job[ ]  Your Response to Stress [ ]  Communication with Parents and Others[ ]  School Performance [ ]  Use of Seat Belt / Motorcycle / Bike Helmets[ ]  Making and Keeping Friends |

\* AIDS = Acquired Immune Deficiency Syndrome.

\*\* HIV = Human Immunodeficiency Virus.