CONFIDENTIAL FORM **DO NOT COPY** **NOT FOR RELEASE**

ACOG ADOLESCENT VISIT QUESTIONNAIRE

We strongly encourage you to discuss all issues of your life with your parent(s) or guardian(s). However, unless it is a life threatening issue, the information you give us on this form is CONFIDENTIAL between our doctors and nurses and you. It will not be released without your written consent. If you would like help filling out this form, please let the nurse know. IF YOU DO NOT FEEL COMFORTABLE ANSWERING A QUESTION, LEAVE IT BLANK AND YOUR DOCTOR OR NURSE WILL TALK WITH YOU ABOUT IT.

Name: _____ Age: _____ Today's Date: _____

Why did you come into our office today? _____

General Health: Please answer these general health questions. Ignore the last column. Your doctor or nurse will fill that out.

Friends and Family		**For doctor/nurse use**
Can you talk with your parent(s) or guardian(s) about personal things happening in your life?	❑ Yes ❑ No ❑ Sometimes	
Is there another adult you trust and can talk to if you have a problem?	❑ Yes ❑ No Who?	
Who do you live with? (Please circle all that apply.)	Mother Father Guardian Brother or Sister Other:	
Do you think your family has lots of fun together?	❑ Yes ❑ No ❑ Sometimes	
What do you do for fun?		
Do you think your parents care about you?	❑ Yes ❑ No ❑ Sometimes	
Do you have a best friend?	❑ Yes ❑ No	
School and Work		
Do you like school?	❑ Yes ❑ No ❑ Sometimes ❑ Not in school	
What grade are you in?	Grade: ❑ Not in school	
What school do you go to?	School: ❑ Not in school	
Do you do well in school?	❑ Yes ❑ No ❑ Sometimes ❑ Not in school	
How often have you skipped school?	❑ Never ❑ Once or twice ❑ A lot	
Do you have any learning problems?	❑ Yes ❑ No	
Do you have a job?	❑ Yes ❑ No If yes, doing what?	
Do you know what you want to be when you are older?	❑ Yes ❑ No If yes, what?	
Appearance and Fitness		
Do you have any concerns or questions about the shape or size of your body or the way you look?	❑ Yes ❑ No ❑ Not sure	
Do you want to gain or lose weight?	❑ Gain ❑ Lose ❑ Neither	
Have you ever tried to lose weight or control your weight by throwing up, using diet pills or laxatives, or not eating for a day?	❑ Yes ❑ No	
Have you ever had your body pierced (other than ears) or gotten a tattoo?	❑ Yes ❑ No ❑ Considering	
Do you exercise or participate in a sport at least five times per week that makes you sweat or breathe hard for 30 minutes?	❑ Yes ❑ No	
What sport, dance, or exercise programs do you participate in?		
How many fruits and vegetable portions do you eat each day?	❑ None ❑ 1–2 ❑ 3–4 ❑ 5–6 ❑ 7 or more ❑ Depends	
How many cups of milk, yogurt, ice cream do you eat each day?	❑ None ❑ 1–2 ❑ 3–4 ❑ 5–6 ❑ 7 or more ❑ Depends	

PATIENT NAME:_____

ACOG ADOLESCENT VISIT QUESTIONNAIRE *(continued)*

Safety/Weapons/Violence		**For doctor/nurse use**
Do you wear a seat belt when you ride in a car, truck, or van?	❑ Yes ❑ No ❑ Sometimes	
Do you wear a helmet when you roller blade; skateboard; ride a bike, motorcycle, all-terrain vehicle, mini-bike, scooter; or go snowboarding or skiing? (Circle all activities in which you participate.)	❑ Yes, for all of the activities circled ❑ No, for all of the activities circled ❑ Sometimes If sometimes, please explain:	
Do you or does anyone you live with have a gun, rifle, or other firearm?	❑ Yes ❑ No ❑ Not sure	
Have you ever carried a gun or weapon?	❑ Yes ❑ No	
Have you ever been in trouble with the law?	❑ Yes ❑ No	
Has anyone touched you in a way that made you uncomfortable?	❑ Yes ❑ No ❑ Not sure	
Has anyone ever forced you to have sex?	❑ Yes ❑ No ❑ Not sure	
Has anyone ever hurt you physically or emotionally?	❑ Yes ❑ No ❑ Not sure	
Relationships		
Are you going out with anyone?	❑ Yes ❑ No	
Who do you find yourself attracted to sexually?	❑ Boys ❑ Girls ❑ Both	
Do you ever participate in sexual activities, such as touching or oral or anal sex? If yes, do you use anything to prevent disease?	❑ Yes ❑ No ❑ Yes ❑ No If yes, what do you use?	
Have you ever had sex with anyone? If yes, answer the questions in this section below. If no, do you plan to in the next year? When done answering this question, go to the section "Tobacco, Alcohol, and Drugs."	❑ Yes ❑ No ❑ Yes ❑ No ❑ Not sure	
How many sexual partners have you had in the past 3 months? How many total since you started to have sex?	Over past 3 months: Total:	
How old were you the first time you had sex (intercourse)?	Age:	
Have you ever had sex with a person of your same sex?	❑ Yes ❑ No	
Do you use anything to prevent pregnancy?	❑ Yes ❑ No ❑ Sometimes If yes, what do you use?	
How often do you and your partner(s) use a condom when you have sex?	❑ Always ❑ Sometimes ❑ Never	
Have you ever had sex for money or drugs?	❑ Yes ❑ No	
Are you worried about your parents knowing that you are having sex?	❑ Yes ❑ No	
Tobacco, Alcohol, and Drugs		
Have you or your close friends ever smoked cigarettes or cigars, used snuff, or chewed tobacco?	❑ Yes, I have ❑ No, I have not ❑ Yes, friends have ❑ No, friends have not ❑ Not sure about friends	
Have you or your close friends ever gotten drunk on wine, beer, or alcohol?	❑ Yes, I have ❑ No, I have not ❑ Yes, friends have ❑ No, friends have not ❑ Not sure about friends	
How much alcohol do you drink at one time?	❑ Do not drink ❑ 1–2 drinks ❑ 3 or more	
Do you ever have more than three drinks per occasion?	❑ Do not drink ❑ Yes ❑ No	
In the last year, have you been in a car or other motor vehicle when the driver is drunk or has been drinking alcohol or using drugs? (This includes when you were the driver as well as other people.)	❑ Yes ❑ No	
Would you call your parent(s) or guardian(s) for a ride if you needed to because the person who was supposed to drive you home had been drinking? (This includes when you were the driver as well as other people.)	❑ Yes ❑ No ❑ Not sure	
Have you or your close friends ever used marijuana or other drugs (cocaine, heroin, meth, or ecstasy) or sniffed inhalants (glue, gasoline, or solvents)?	❑ Yes, I have ❑ No, I have not ❑ Yes, friends have ❑ No, friends have not ❑ Not sure	
Have you ever used a prescription drug to get high?	❑ Yes ❑ No ❑ Not sure	

ACOG ADOLESCENT VISIT QUESTIONNAIRE *(continued)*

PATIENT NAME:_____

Have you ever used alcohol or drugs so much that you could not remember what happened (had a blackout)?	❑ Do not use drugs or alcohol ❑ Yes ❑ No	
Have you ever missed work or school because of using alcohol or drugs?	❑ Do not use drugs or alcohol ❑ Yes ❑ No	
Emotions		
Do you have more happy days or unhappy days?	❑ Happy ❑ Unhappy	
Have you ever seriously thought about hurting yourself?	❑ Yes ❑ No	
Do you get nervous or anxious more than other people do?	❑ Yes ❑ No	
During the past year, have you had any major good or bad changes in your life (death of someone close, loss of a pet, birth, graduation, moving, change of school, ending or starting a close friendship or romantic relationship)?	❑ Good ❑ Bad ❑ No changes ❑ Some good, some bad	
Tell me something good about yourself.		

What would you like to discuss with our nurses and doctors today?_____

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Source: American Medical Association, Copyright 1998.