ADVANCED gynecology Specialists of Augusta

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 provide on this form is confidential between Dr. Thaxton, his nurses and you. It will not be released without your written consent. If you would like help in completing this form, please let the nurse know. **If you don't feel comfortable answering a question, leave it blank and Dr. Thaxton or his nurse will talk to you about it.**

Name _____ Age _____ Today's Date _____

Why did you come to our office today? _____

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Please answer these general questions. The last column is for Dr. Thaxton and his nurse to use for notes

FRIENDS AND FAMILY		For doctor/nurse use
Can you talk with your parent(s) or guardian(s) about personal things happening to you?	☐ Yes ☐ No	
If not, is there another adult you trust and can talk to if you have a problem?	☐ Yes ☐ No Who?	
With whom do you live? (Please circle all that apply)	Mother, Father, Guardian, Siblings Other:	
Do you think your family has lots of fun together?	☐ Yes ☐ No	
Do you think your parents care about you?	☐ Yes ☐ No	
Do you have a best friend?	☐ Yes ☐ No	
SCHOOL AND WORK		
Do you like school?	☐ Yes ☐ No ☐ Not in school	
Do you do make good grades in school?	☐ Yes ☐ No ☐ Not in school	
What grade are you in?	Grade: ☐ Not in school	
What school do you attend?	School: ☐ Not in school	
How often have you skipped school?	☐ Never ☐ Once or twice ☐ A lot	
Do you have any learning problems?	☐ Yes ☐ No Doing what?	
Do you have a job?	☐ Yes ☐ No Doing what?	
Do you know what you want to be when you are older?	☐ Yes ☐ No 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 had a tattoo?	☐ Yes ☐ No	

APPEARANCE AND FITNESS CONTINUED		For doctor/nurse use
Do you exercise or participate in a sport at least for at least 30 minutes 5 times a week that makes you breathe hard or sweat?	☐ Yes ☐ No	
How many fruits and vegetables do you eat each day?	☐ None ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7 or more	
How much milk, ice cream or yogurt do you each daily?	☐ None ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7 or more	
SAFETY/WEAPONS/VIOLENCE		
Do you wear a seat belt when drive or ride?	☐ Yes ☐ No	
Do you wear a helmet when you ride a bike, motorcycle, ATV, mini-bike, skateboard, rollerblade or scooter?	☐ Yes ☐ No	
Do you or anyone you live with have a gun, rifle or other firearm?	☐ Yes ☐ No ☐ Not sure	
Have you ever carried a gun or a weapon?	☐ Yes ☐ No	
Have you ever been in trouble with the law?	☐ Yes ☐ No	
Has anyone ever touched you in a way that made you feel 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 sexually attracted to?	☐ Girls ☐ Boys ☐ Both	
Have you ever had sex with anyone? If your answer is yes, complete the question in this section. If no, complete the next question only.	☐ Yes ☐ No	
If you answered no, do you plan to have sex with anyone in the next year? Skip the questions below and advance to the section on tobacco, alcohol and drugs.	☐ Yes ☐ No ☐ Not sure	
How many partners do you have now? In the past?	Now: In the past:	
How old were you when you first had intercourse?	Age:	
Have you ever had sex with anyone of your same sex?	☐ Yes ☐ No	
Do you use anything to prevent pregnancy"	☐ Yes ☐ No If yes, what?	
Does your partner always use a condom with you?	☐ Yes ☐ No	
Do you ever have sex for money or drugs?	☐ Yes ☐ No	
Are you worried about your parents knowing you are having sex?	☐ Yes ☐ No	
Do you ever participate in other sexual activities such as touching, oral or anal sex?	☐ Yes ☐ No	
If yes, do you use anything to prevent disease?	☐ Yes ☐ No If yes, what?	
TOBACCO, ALCOHOL AND DRUGS		
Do you smoke cigarettes or cigars, use snuff or chew tobacco?	☐ Yes ☐ No	
Do your friends smoke cigarettes or cigars, use snuff or chew tobacco?	☐ Yes ☐ No ☐ Not sure	
How you ever gotten drunk on wine, beer or liquor?	☐ Yes ☐ No	
Have your friends ever gotten drunk on wine, beer or liquor?	☐ Yes ☐ No ☐ Not sure	
Do you currently drink? If no, skip next two questions.	☐ Yes ☐ No	

TOBACCO, ALCOHOL AND DRUGS CONTINUED		For doctor/nurse use
If you drink, how much alcohol do you drink at one time?	☐ 1-2 drinks ☐ 3 or more drinks	
If you drink, do you ever drink 5 drinks in a row?	☐ 1-2 drinks ☐ 3 or more drinks	
Have you ever used marijuana or other drugs (like cocaine, heroin or ecstasy) or sniffed inhalants?	☐ Yes ☐ No	
Have your friends ever used marijuana or other drugs (like cocaine, heroin or ecstasy) or sniffed inhalants?	☐ Yes ☐ No ☐ Not sure	
Have you ever used drugs or alcohol so much you could not remember what happened?	☐ Do not use drugs or alcohol ☐ Yes ☐ No	
Have you ever missed work or school because of use of drugs or alcohol?	☐ Do not use drugs or alcohol ☐ Yes ☐ No	
In the past year have you been in a car or other motor vehicle accident when the driver was drunk or had been drinking or using drugs? This includes you as a driver as well as other people.	☐ Yes ☐ No	
Would you call your parent(s) or guardian(s) for a ride if you were stranded because the person who was supposed to drive you home had been drinking? This includes you any other people.	☐ Yes ☐ No ☐ Not sure	
EMOTIONS		
In the past few weeks, have you often felt sad or down as though you have nothing to look forward to?	☐ Yes ☐ No	
Have you ever thought about killing yourself, made a plan to kill yourself or actually tried to kill yourself?	☐ Yes ☐ No	
During the past year have you had any major good or bad changes in your life (death of someone close, birth, graduation, breakup with boyfriend or girlfriend, etc.?)	☐ Good ☐ Bad ☐ No changes	
If you answered no, do you plan to have sex with anyone in the next year? Skip the questions below and advance to the section on tobacco, alcohol and drugs.	☐ Yes ☐ No ☐ Not sure	

Would you like to discuss anything with Dr. Thaxton or his nurse today? _____

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Select questions have been taken directly or adapted from the following sources, with permission: GAPS—Younger Adolescent Questionnaire, American Medical Association 1998; Middle-Older Adolescent Questionnaire, American Medical Association 1997.