Adolescent Well Visit Questionnaire
Ages 16-18yrs.

(To be filled out by the patient, not parent or guardian, please)

Name_____Date_____Chart # (office use)_____

Date of birth_____Age_____Sex M / F (circle one) Grade in School_____

Specific Health Concerns (Please mark any of the following that you have concerns with)

☐ Height/weight	☐ Breasts	☐ Nutrition
☐ Headaches	☐ Nausea, vomiting, stomach pain	☐ Physical/sexual abuse
☐ Ears, nose, mouth, throat	☐ Skin conditions	☐ School
☐ Chest pain/heart	☐ Trouble sleeping	☐ Physical activity
☐ Coughing/Wheezing	☐ Sexual organs/ genitals	☐ Other

Health /Nutrition (These questions will help your provider assess your health and well-being)

Are you satisfied with your eating habits? ..... ☐ Yes ☐ No
Do you ever eat in secret? ..... ☐ Yes ☐ No
In the last year, have you tried to lose weight by vomiting, taking pills or not eating? ..... ☐ Yes ☐ No

School

Are your grades this year worse than your grades last year? ..... ☐ Yes ☐ No
Have you been suspended from school or frequently in trouble this year? ..... ☐ Yes ☐ No
Are you concerned/worried about future plans? ..... ☐ Yes ☐ No

Social/Emotional

Do you have at least one friend who you really like and feel you can talk to? ..... ☐ Yes ☐ No
Do you think your parents/guardians usually listen to you and take your feelings seriously? ..... ☐ Yes ☐ No
In your opinion, is there a lot of tension or conflict in your home? ..... ☐ Yes ☐ No
Have you had fun during the past 2 weeks? ..... ☐ Yes ☐ No
In general, are you happy with your life currently? ..... ☐ Yes ☐ No
During the past few weeks, have you often felt sad or down? ..... ☐ Yes ☐ No
Have you ever been physically, emotionally or sexually abused? ..... ☐ Yes ☐ No
Have you ever run away from home overnight? ..... ☐ Yes ☐ No
Have you ever seriously thought of suicide, made a plan or attempted suicide? ... ☐ Yes ☐ No

Weapons/ Violence

Are there guns in your home? ☐ Yes ☐ No
In the past year, have you carried a gun, knife, club or other weapon for your protection? ☐ Yes ☐ No
Have you been in a physical fight in the past year? ☐ Yes ☐ No
Have you ever been in trouble with the law? ☐ Yes ☐ No

Tobacco/Alcohol/Drugs

Do you ever smoke, vape or chew tobacco? ☐ Yes ☐ No
Do any of your close friends ever smoke, vape or chew tobacco? ☐ Yes ☐ No
Does anyone in your home ever smoke, vape or chew tobacco? ☐ Yes ☐ No
In the past month, did you get drunk or buzzed on alcohol? ☐ Yes ☐ No
In the past month, did any of your friends get drunk or buzzed? ☐ Yes ☐ No
In the past year, have you been in a car or motor vehicle when the driver has been using drugs or alcohol? ☐ Yes ☐ No
In the past year, have you operated a motor vehicle while or after using drugs and or alcohol? ☐ Yes ☐ No o
Do you ever use marijuana? Other drugs or inhalants? ☐ Yes ☐ No
Do any of your close friends use marijuana or other drugs? ☐ Yes ☐ No
Some drugs can be bought at a store without a doctor's prescription. Do you ever use these drugs to get to sleep, stay awake, calm down or get high? ☐ Yes ☐ No

Development

Do you have any concerns or questions about your physical appearance? ☐ Yes ☐ No
Are you physically and emotionally attracted to people of your own sex? ☐ Yes ☐ No
Have you ever had sexual intercourse? ☐ Yes ☐ No
If so, are you using birth control? ☐ Yes ☐ No
Have any of your friends had sexual intercourse? ☐ Yes ☐ No
Do you have any questions or concerns about sex, relationships or STD's? ☐ Yes ☐ No
Would you like information on being tested for STD's? ☐ Yes ☐ No

Self

What do you like best about yourself?_____
What do you do best?_____
If you could, what would you change about your life or yourself?_____
_____