Guidelines for Adolescent Preventive Services

Periodic Adolescent Preventive Services Visit Form

Confidential

Name ______________________________________ Date__________
Last First Middle Initial

Date of birth__________________ Sex M F Age __________ Grade in school __________

Your reason for today's visit ______________________________________

Specific Health Concerns

Please check whether you have questions or concerns about any of the following:

☐ Height/weight	☐ Mouth/teeth	☐ Diarrhea/constipation	☐ Tiredness
☐ Blood pressure	☐ Neck/back	☐ Skin (rash, acne)	☐ Diet/food/appetite
☐ Headaches/migraines	☐ Chest pain	☐ Muscle or joint pain in arms/legs	☐ Future plans/job
☐ Dizziness/passing out	☐ Coughing/wheezing	☐ Frequent or painful urination	☐ Physical or sexual abuse
☐ Eyes/vision	☐ Breasts	☐ Wetting the bed	☐ Masturbation
☐ Ears/hearing/earaches	☐ Heart	☐ Sexual organs/genitals	☐ Cancer
☐ Nose	☐ Stomach pain	☐ Menstruation/periods	☐ Dying
☐ Frequent colds	☐ Nausea/vomiting	☐ Trouble sleeping	☐ Other (explain)

Health Profile

These questions will help us get to know you better. Choose the answer that best describes what you feel or do. Your answers will be seen only by your health care provider and his/her assistant.

Eating/Weight

1. Are you satisfied with your eating patterns? ☐ No ☐ Yes
2. Do you ever eat in secret? ☐ Yes ☐ No
3. In the past year, have you tried to lose weight or control your weight by vomiting, taking diet pills or laxatives, or starving yourself? ☐ Yes ☐ No

School

4. Are your grades this year worse than your grades the year before? ☐ Yes ☐ No ☐ Not in school
5. Are you in special education classes? ☐ Yes ☐ No
6. Have you been suspended from school this year? ☐ Yes ☐ No

Friends & Family

7. Do you have at least one friend who you really like and feel you can talk to? ☐ No ☐ Yes
8. Do you think that your parent(s) or guardian(s) *usually* listen to you and take your feelings seriously? ☐ No ☐ Yes
9. In your opinion, is there a lot of tension or conflict in your home? ☐ Yes ☐ No ☐ Not sure

Weapons/Violence

10. Do you or anyone you live with have a gun, rifle, or other firearm in your home? ☐ Yes ☐ No ☐ Not sure
11. In the past year, have you carried a gun, knife, club, or other weapon for your protection? ☐ Yes ☐ No
12. Have you been in a physical fight during the *past 3 months*? ☐ Yes ☐ No
13. Have you ever been in trouble with the law? ☐ Yes ☐ No

Tobacco

14. Do you ever smoke cigarettes or use smokeless tobacco (snuff or chewing tobacco)? ☐ Yes ☐ No
15. Do any of your close friends ever smoke cigarettes or use smokeless tobacco (snuff or chewing tobacco)? ☐ Yes ☐ No
16. Does anyone you live with smoke cigarettes or use smokeless tobacco? ☐ Yes ☐ No

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Alcohol

17. In the past month, did you get drunk or very high on beer, wine, wine coolers, or other alcohol? ... ☐ Yes ☐ No
18. In the past month, did any of your friends get drunk or very high on beer, wine, wine coolers, or other alcohol? ... ☐ Yes ☐ No
19. Have you ever used alcohol *and* then done any of the following: • driven a car/truck/van/ motorcycle • gone swimming or boating • gotten into a fight • used tools or equipment • done something that you later regretted? ... ☐ Yes ☐ No
20. Have you ever been criticized or gotten into trouble because of drinking? ... ☐ Yes ☐ No ☐ Not sure
21. In the past year, have you been in a car or other motor vehicle when the driver has been drinking alcohol or using drugs? ... ☐ Yes ☐ No
22. Does anyone in your family have a problem with drugs or alcohol? ... ☐ Yes ☐ No

Drugs

23. Do you ever use marijuana, other drugs or inhalants? ... ☐ Yes ☐ No ☐ Not sure
24. Do any of your close friends ever use marijuana, other drugs or inhalants? ... ☐ Yes ☐ No ☐ Not sure
25. Some drugs can be bought at a store without a doctor's prescription. Do you ever use non-prescription drugs to get to sleep, stay awake, calm down, or get high? ... ☐ Yes ☐ No
26. Have you ever used steroids (eg, "roids or juice")? ... ☐ Yes ☐ No ☐ Not sure

Development

27. Do you have any concerns or questions about the size or shape of your body, or your physical appearance? ... ☐ Yes ☐ No ☐ Not sure
28. Are you physically and emotionally attracted to people of your own sex? ... ☐ Yes ☐ No ☐ Not sure
29. Have you ever had sexual intercourse? ... ☐ Yes ☐ No ☐ Not sure
30. Are you using birth control? ... ☐ No ☐ Yes ☐ Not sure
31. Do you and your partner *always* use condoms when you have sex? ... ☐ No ☐ Yes ☐ Not sure
32. Have any of your friends ever had sexual intercourse? ... ☐ Yes ☐ No ☐ Not sure
33. Have you ever been told by a doctor or nurse that you had a sexually transmitted disease (STD) such as genital herpes, gonorrhea (drip), chlamydia, trichomoniasis ("trick"), hepatitis, genital warts, HIV infection, or others? ... ☐ Yes ☐ No ☐ Not sure
34. Do you have any questions or concerns about sex, relationships or STDs? ... ☐ Yes ☐ No ☐ Not sure
35. Would you like to receive information or supplies *today* to prevent pregnancy or sexually transmitted diseases? ... ☐ Yes ☐ No ☐ Not sure
36. Would you like to know how to avoid getting the HIV/AIDS virus? ... ☐ Yes ☐ No ☐ Not sure

Emotions

37. Have you had fun during the past two weeks? ... ☐ No ☐ Yes
38. In general, are you happy with the way things are going for you these days? ... ☐ No ☐ Yes ☐ Not sure
39. During the past few weeks, have you *often* felt sad or down or as though you have nothing to look forward to? ... ☐ Yes ☐ No
40. Have you ever *seriously* thought about killing yourself, made a plan to kill yourself, or actually tried to kill yourself? ... ☐ Yes ☐ No
41. Have you ever been physically, sexually, or emotionally abused? ... ☐ Yes ☐ No ☐ Not sure

Special Circumstances

42. In the past year, have you been exposed to tuberculosis? ... ☐ Yes ☐ No ☐ Not sure
43. In the past year, have you stayed over night in a homeless shelter, jail, or detention center? ... ☐ Yes ☐ No
44. Have you ever run away from home overnight? ... ☐ Yes ☐ No
45 Have you ever lived in foster care or an institution? ... ☐ Yes ☐ No

Self

46. What do you like about yourself? ____________________
47. What do you do best? ____________________
48. If you could, what would you change about your life or yourself? ____________________

Thank you for completing this form.

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