

WORKSHEET TO BE COMPLETED BY TEEN: This worksheet can give your health care team information to help you take better care of yourself. You don't have to answer any questions you don't want to. Your health care provider will enter this information into Group Health's secure medical record system. **Group Health values your privacy. Your answers will be kept confidential.**

Name:		
Confidential phone number:	Is it okay to leave a message?	
What are your MAIN REASONS for today's visit?		For clinic use
<input type="checkbox"/> Physical exam <input type="checkbox"/> Sports exam <input type="checkbox"/> Camp exam <input type="checkbox"/> Other concerns, please list: _____		Chief Complaint
Family, School, and Other Activities		
Who are the people that live with you? (include names, ages, relationships):		History: Social Documentation
Are you in school? If so, which school do you go to? What grade or year are you in?	<input type="checkbox"/> Yes <input type="checkbox"/> No	hx sot
Are you having a hard time in school?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have a job outside of school? If YES, what: In this job, do you work more than 20 hours a week?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
What sports, activities, and hobbies are you involved in?		
Medical History: Check box if you have, or ever had, any of the following?		
<input type="checkbox"/> Asthma	<input type="checkbox"/> Mental health problem	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Chlamydia/STD	<input type="checkbox"/> Seizure/epilepsy	<input type="checkbox"/> Genital warts
<input type="checkbox"/> Learning disability/ADD	<input type="checkbox"/> Depression/anxiety	<input type="checkbox"/> Heart problems
<input type="checkbox"/> Allergies	<input type="checkbox"/> Surgeries	<input type="checkbox"/> Chickenpox If yes, how old were you?
List other major illnesses, operations, hospitalizations, injuries, or conditions (describe and give year):		History: Medical/Surgical
Family History		
Check here if you know you were adopted <input type="checkbox"/>		History: Family
Please check boxes below if you have any family members who have had any of following: Which family members?		
<input type="checkbox"/> Depression/suicide	_____	
<input type="checkbox"/> Diabetes	_____	
<input type="checkbox"/> Alcohol/drug problems	_____	
<input type="checkbox"/> Asthma/allergies	_____	
<input type="checkbox"/> Other illnesses/conditions	_____	
Medications		
List any medications you're taking including prescription, herbal, and over-the-counter		Medications
Sports		
Have you ever:		Progress Note
Passed out while exercising?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Gotten dizzy or had headaches while exercising?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Been knocked out?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Had a significant joint or bone problem?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Had a serious injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Can you run twice around a ¼ mile track without stopping?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have a family member with heart disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have a family member who died suddenly before the age of 50?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

PLEASE CONTINUE ON BACK PAGE

NOT TO BE FILED IN THE MEDICAL RECORD

Preventive Care Visit

Teens Ages 13 - 21

Nutrition		
Do you eat fruits and vegetables every day?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Progress Note
Do you eat or drink dairy products?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Safety		
If you ride a motorcycle or bicycle, do you always use a helmet?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Progress Note
Do you always use your seat belt when in a car?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you ever drive or ride when the driver has had alcohol or drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you or any of your friends have access to guns?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Has anyone ever touched you in a way that made you uncomfortable or afraid?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Stress		
Do you get along with your parents?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Progress Note
Are you having a hard time at home?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you happy with the number of friends you have?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have a best friend to talk with about any problems you might have?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you having a hard time with friends?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you having trouble with fighting or bullying?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you feeling pressure to do what others are doing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have any concerns about your body or weight?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
During the past 2 years, have you or anyone in your family had any major good or bad changes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Depression		
Have you had little interest or pleasure in doing things?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If YES to either, complete PHQ-9 depression workflow
Have you been feeling down, depressed, irritable, or hopeless?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Tobacco, Alcohol and Drugs		
Do you use tobacco (smoke or chew)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Social: Substance & Sexuality
Do you drink alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
IF YES, how many drinks per week? (1 drink=1 glass beer, wine, or hard liquor drink)	<input type="checkbox"/> 1-5 <input type="checkbox"/> 6-10 <input type="checkbox"/> 10+	
How often do you have 4 or more drinks on one occasion?	<input type="checkbox"/> Never <input type="checkbox"/> Sometimes <input type="checkbox"/> Often	
Have you used or do you have questions about any other substances or drugs other than alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Sexuality		
Are you attracted to	<input type="checkbox"/> Males <input type="checkbox"/> Females <input type="checkbox"/> Both <input type="checkbox"/> Not sure	Social: Substance & Sexuality
Have you ever had sex?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If YES, are, or were, your sexual partners:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> both	
When you have sex, how often do you use a condom?	<input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Never	
When you have sex, how often do you, or does your partner, use protection from pregnancy?	<input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Never <input type="checkbox"/> Doesn't apply to me	
If you use or your partner uses protection, what kind do you or your partner use (please list):		
Have you ever been pregnant or made someone pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
For Females		
Have your periods started?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Progress Note
IF YES, when did they start?	Month and Year:	
IF YES, are they regular?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do menstrual cramps keep you from doing your normal activities?	<input type="checkbox"/> Yes <input type="checkbox"/> No	