

INSTRUCTIONS: To be completed by patients twelve (12) and over. Please fill in the blanks or check the appropriate answer as best you can. This questionnaire is a valuable aid to your doctor's understanding of your health.

Name: _____ MRN Number: _____

Date: _____

Are you taking any medications?

Yes No If Yes, list them and how often you take them.

Do you have any allergies?

Yes No If Yes, please list: _____

I. DEVELOPMENTAL HISTORY:

What grade are you presently in? _____

Are your grades: Average Above Average Below Average

Have you repeated any grade in school? Yes No

Are you having any school problems? _____

Do you have a part-time or full-time job? Yes No

Do you have any hobbies? Do you belong to any youth groups? Are you active in any sports?

Do you have any career plans? _____

Do you smoke? Yes No Do you drink or use other drugs? Yes No

Are you sexually active? Yes No If Yes, do you use any form of birth control? _____

For Female Patients

Are you having menstrual periods? Yes No If Yes, at what age did you have your first period? _____

Are your periods regular? Yes No How many days do they last? _____

Do you have problems or concerns about your menstrual periods? _____

When was your last period? _____

Continued - Please Turn Page

II. REVIEW OF SYSTEMS:

- | | YES | NO |
|----------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. Do you think something is wrong with your general health? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you concerned about your weight or your height? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Has your appetite decreased? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you lost or gained weight recently? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you tire easily? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you think something is wrong with your eyes? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you have any concerns about your skin? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have frequent headaches? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you have trouble breathing? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you get short of breath, wheeze or cough frequently? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you have chest pain? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you think something is wrong with your heart? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you often have stomach aches? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have diarrhea or constipation? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Do you often have backaches, sore bones, joints or muscles? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Do you have trouble sleeping? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Do you have frequent dreams or nightmares? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Are you often upset or sad? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Are you having problems with your parents, brothers or sisters? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Do you have difficulty making friends? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Does it burn when you urinate? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Do you wet the bed? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Are you concerned about your sexual development or sexual feelings? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Do you have questions about birth control? | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Is there any question about sexual matters you would like to ask? | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Do you have any questions about discharge from your sex organs or
questions about venereal disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Do you have questions about drugs or alcohol? | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Do you drive? | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Do you use seat belts? | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. If you have a problem, what do you do? _____ | | |
