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ADOLESCENCES ADDENDUM (13- 18 yrs)

To be filled out by patient if between the age of 13-18.

Medical History:

What are your health concerns, in order of importance?

1)____

2)____

3)____

4)____

Do you do/ take any of the following (check)?

smoke, if so, how many packs per day week ______________________

alcohol, if so, how much and how often _______________________

recreational drugs, if so, how much and how often _______________________

others ____

Psychosocial:

How would you describe your

- relationship with parents:	Excellent	Good	OK	Poor
- relationship with siblings:	Excellent	Good	OK	Poor
- relationship with friends:	Excellent	Good	OK	Poor

Do you enjoy school? Yes No

What do you like/ dislike about school?

____

What is your stress level? Please rate on a scale of 1 (least) to 10 (most) for the following:

Home: School: Other (list): ____________________

List extra-curricular activities and hobbies: (sports teams, bands, piano lessons, etc.):

____

____

List your goals (future goals, career, etc.):

____

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How much TV do you watch? _________ hrs per
How often do you play video games? _________ hrs per
How often do you use the internet/ computer? _________ hrs per
Do you exercise? Yes No If yes, what type of exercise, how much and how often:
____

MALE
Age of onset of puberty: _________
Have you noticed any change in the penis and scrotum? __________________________
Are you familiar with normal growth patterns, nocturnal emissions ("wet dreams"), and sex education?
____

FEMALE
When did you notice your breasts were changing? ______________________________
How old were you when you had your first period? _____________________________
Average # of bleeding days (period) _____ Average # of days between bleeding _____
Is there bleeding between periods? _________________

Sexual History:
Are you sexually active? Yes No If yes, please continue.
What type of birth control do you use (none or list)?
____
Have you been tested for STD's/ venereal diseases? Yes No If yes, which ones?
____
Sexual Preference: _______________________
Female: When was your last PAP test? _______________
Female: Have you ever been pregnant, had a live birth, miscarriage or abortion?
____
Is there anything you feel is important that has not been addressed?
____
____