Delaware Valley Pediatric Associates:
Adolescent Patient History

Please complete this form prior to being seen by the doctor. Answer each question as best you can. This information will help us to get to know you better. If you have any questions, please discuss them with the doctor.

Name:_____ Today's Date:_____ Age:____ School Grade:_____
Reason for today's visit:_____

Comments:

1. Do you get along well with your parents?	Yes___	No___
2. Do you get along well with your brothers and sisters?	Yes___	No___
3. Do you have any really close friends?	Yes___	No___
4. Do your parents get along well with each other?	Yes___	No___
5. Have your parents ever considered separation or divorce?	No___	Yes___
6. Is your family under any serious stress?	No ___	Yes___
7. Do you like to have your friends visiting your home?	Yes___	No___
8. Are you doing all right in school?	Yes___	No___
9. Do you miss more than two days of school each month?	Yes___	No___
10. Have you ever considered dropping out of school?	No ___	Yes___
11. Have you ever repeated a grade in school?	No ___	Yes___
12. Have you ever been sexually or physically abused?	No ___	Yes___
13. Do you smoke cigarettes?	No ___	Yes___
14. Have you ever been drunk?	No ___	Yes___
15. Do any of your friends use drugs?	No ___	Yes___
16. Do you use, or have you used in the past, any of the following: marijuana, crack, cocaine, heroine, other street drugs?	No ___	Yes___
17. Have you ever driven in a car with someone who was drunk?	No ___	Yes___
18. Do you wear a helmet when on a bicycle?	Yes___	No___
19. Is there a gun in your home?	No ___	Yes___
20. Have you ever been in trouble with the law?	No ___	Yes___
21. Do you have anyone to talk over your problems with?	Yes___	No___
22. Is life generally okay for you?	Yes___	No___
23. Have you lost a lot of weight recently?	No ___	Yes___
24. Do you worry that you are too thin or too fat?	No ___	Yes___
25. Do you exercise regularly?	Yes___	No___
26. Do you do any volunteer or community service?	Yes___	No___
27. Do you have any special interests or hobbies?	Yes___	No___
28. For *females* only…		
a. Do you have menstrual periods every month?	Yes___	No___
b. Have you ever had a breast lump?	No ___	Yes___
c. Do you have a boyfriend/girlfriend?	No ___	Yes___
d. Have you ever been pregnant?	No ___	Yes___
e. Are you concerned that you might be pregnant?	No ___	Yes___
29. For *males* only…		
a. Do you have a girlfriend/boyfriend?	No ___	Yes___
b. Are you concerned that you might get someone pregnant?	No ___	Yes___
c. Have you ever had sores or discharge from your penis?	No ___	Yes___
d. Do you examine your testicles for lumps?	Yes___	No___
30. Have you ever seriously thought about hurting yourself?	No ___	Yes___

31. Have you ever had any of the following problems? (*circle if appropriate*)

anemia	heart murmur	thyroid problems	frequent nervousness
asthma	hepatitis	blood transfusion	frequent headaches
chlamydia	high blood pressure	pain with urinating	trouble sleeping
gonorrhea	high cholesterol	tire easily	other_____

Please circle if you would like to discuss any of the following topics with your doctor:

acne	sexual development	AIDS
weight problems	friend problems	sex
menstruation	parent problems	drugs
pregnancy	depression/sadness	other:_____