## CONFIDENTIAL INFORMATION

## 13-15 YEAR OLD FEMALES:

PATIENTS complete the section below and HAND TO THE NURSE when you have completed the form.

This form will be shredded after the doctor has read the form.

1. Do you have any school concerns (circle one) such as poor grades, lack of motivation, loss of interest, dis	ficulty	
concentrating, completing assignments, behavior, or excessive absences from school?	DNO	
2. Do you have any concerns about your weight?		
3. Do you have any body piercings (other than earrings) or tattoos?		
4. In the past year have you tried to lose weight by vomiting, taking pills, laxatives, or		
starving yourself?	□N.1	
5. Do you have any concerns about (circle one) your breasts, menstruation, pelvic pain,	UNO	
vaginal lesions (sores), or vaginal discharge?		
Do you have problems with menstruation such as excessive pain or excessive pain or flow	⊔No	
When was your last menstrual period?  6. Are you sexually active pow?	UNO	
6. Are you sexually active now?		
If you answered yes above, please answer the questions below:	ĽNO	
Does your partner always use a condom?		
Have you ever been programt?	⊔No	
Have you ever been pregnant?	□No	
Do you have any children?	□No	
Have you ever been treated for a sexually transmitted disease? Yes	□No	
Are you interested in starting and are your interested in the your in	□No	
Are you interested in starting oral contraceptives?	$\square N_{O}$	
7. Do you have any concerns about inappropriate sexual behavior or sexual orientation?	□No	
8. Have you ever been physically or sexually mistreated or abused?	□No	
9. Do you have any social concerns: (lack of friends, poor relationships with parents, siblings,		
friends, teachers)?	$\square No$	
10. Do you have any behavioral concerns: (temper outbursts, excessive risk taking,		
aggression, violence)?	□No	
II. Do you smoke cigarettes?	□No	
12. Do you ever use marijuana, cocaine, inhalants, steroids, other?		
13. Do you have concerns that you may not graduate from High School?		
14. Do you always use a safety belt when riding in a car?		
15. Does anyone have a gun in your home?		
16. Do you exercise regularly?		
17. Do you spend more than 2 hours per day watching TV or playing video games?	□No	
17. Flow many ounces of milk do you drink in a day? What kind of milks		
18. How many cups of soda/juice/energy drinks do you drink in a day?		
Please tell us the names and ages of your brothers and sisters		
Patient lives with: Mom Dad Both Together Both Separately		
Do you have any concerns you wish to discuss?	□No	



## Patient Health Questionnaire-2

Name:	Date:
Over the past 2 bothered by ar	weeks, how often have you been by of the following problems:
	est or pleasure in doing things Not at all
1 =	Several days
2 =	More than half the days
3 =	Nearly every day
<ul> <li>Feeling down, depressed, or hopeless</li> <li>0 = Not at all</li> </ul>	
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2 =	More than half the days
3 =	Nearly every day