

13-15 YEAR OLD MALES:

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, difficulty concentrating, completing assignments, behavior, or excessive absences from school? Yes No
- 2. Do you have any concerns about your weight? Yes No
- 3. Do you have any body piercings (other than earrings) or tattoos?..... Yes No
- 4. In the past year have you tried to lose weight by vomiting, taking pills, laxatives, or starving yourself? Yes No
- 5. Do you have any concerns about a lesion or mass in your scrotum or testes? Yes No
- 6. Are you sexually active now?..... Yes No

If you answered yes above, please answer the questions below:

- Do you always use a condom? Yes No
- Have you ever been treated for a sexually transmitted disease? Yes No
- Do you have any discharge from your penis?..... Yes No

- 7. Do you have any concerns about inappropriate sexual behavior or sexual orientation? Yes No
- 8. Have you ever been physically or sexually mistreated or abused? Yes No
- 9. Do you have any social concerns: (lack of friends, poor relationship with parents, siblings, friends, teachers)? Yes No
- 10. Do you have any behavioral concerns: (temper outbursts, excessive risk taking, aggression, violence)? Yes No
- 11. Do you smoke cigarettes? Yes No
- 12. Do you ever use marijuana, cocaine, inhalants, steroids, other? Yes No
- 13. Do you have concerns that you may not graduate from High School? Yes No
- 14. Do you always use a safety belt when riding in a car? Yes No
- 15. Does anyone have a gun in your home? Yes No
- 16. Do you exercise regularly?..... Yes No
- 17. Do you spend more than 2 hours per day in front of the TV/computer/video game?..... Yes No
- 18. How many ounces of milk do you drink in a day? _____ What kind of milk? _____
- 19. 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? Yes No



Patient Health Questionnaire-2

Name: _____ Date: _____

Over the past 2 weeks, how often have you been bothered by any of the following problems:

- Little interest or pleasure in doing things

0 = Not at all

1 = Several days

2 = More than half the days

3 = Nearly every day

- Feeling down, depressed, or hopeless

0 = Not at all

1 = Several days

2 = More than half the days

3 = Nearly every day