Ages 14-17 Year Health Survey (2 SIDES)

Name_____

Allergies?_____

Meds?_____

Vitamins?_____

Family:
Have there been any significant change in your family life this year? (i.e. move, divorce, illness, etc)

- ☐ No
- ☐ Yes_____

General health:
Are there any health issues you would like to discuss today? Please pick the **2 most important** you would like covered:

_____

Education:
School/grade_____
Any concerns?

- ☐ No
- ☐ Yes_____

Any difficulty in classes or failing any subjects?

- ☐ No
- ☐ Yes_____

Any trouble completing homework or other assignments:

- ☐ No
- ☐ Yes_____

Any difficulty with teachers, friends, peers:

- ☐ No
- ☐ Yes_____

How many hours of non-school related computer/TV/video on a TYPICAL day?_____

Activities:
What physical activities do you participate in and how often? (i.e. soccer/dance)

_____

What other organized activities does you participate in and how often? (i.e. art/music)

_____

Sleep:
Any concerns?_____

How many hours on a TYPICAL night?_____

Bowel Movements:
Do you have painful, infrequent or hard to pass stools?

- ☐ NO
- ☐ YES_____

Dental:
Any dental concerns?

- ☐ NO
- ☐ YES_____

Do you see the dentist twice yearly?

- ☐ NO (last seen_____)
- ☐ YES

Nutrition:
Are you on a modified diet (i.e. vegan, vegetarian, gluten or dairy free)?

- ☐ No
- ☐ Yes, _____

Do you have any **concerns** about your diet?

- ☐ No
- ☐ Yes, _____

Does you have any concerns about your physical appearance?

- ☐ No
- ☐ Yes, _____

***PLEASE COMPLETE THE SECOND SIDE →**

On a **typical** day, how many servings do you eat:

Fruit (serving = 1 tennis ball) _____
Vegetable (serving = ½ baseball cooked, 1 baseball fresh)

_____
Dairy (serv = 1 cup milk/yogurt, 1.5 oz cheese)____
Fish/Egg/Red Meat or Poultry (2-3 oz meat/fish/chicken/tofu,
2 tbsp nut butter, 1-2 eggs, ½ cup beans)_____

CONFIDENTIAL INFORMATION:
What is your **gender identity**?
Female / Male / Non-binary / Prefer not to answer

What is your **sexuality**?
Straight / Lesbian / Gay / Bi / Trans / Queer / Other

Do you have **preferred pronouns**?_____

Are you in a relationship? YES / NO

Have you ever had sex? YES / NO

If yes, please circle any that apply:
Oral / Vaginal / Anal / Prefer not to answer

Are you **currently** sexually active?
YES / NO / Prefer not to answer

If yes, do you/your partner use contraceptives?
YES / NO / SOMETIMES

If YES, what type?_____

Safety:
Do you feel safe at home?

- ☐ YES
- ☐ NO_____

Do you feel safe at school?

- ☐ YES
- ☐ NO_____

Do you feel safe with your friends and/or partner?

- ☐ YES
- ☐ NO_____

Do you wear a seatbelt when riding in a vehicle?

- ☐ Yes
- ☐ No
- ☐ Sometimes

Do you wear a helmet for biking, skiing, skating, scootering, ATVing, motorbiking?

- ☐ Yes
- ☐ No
- ☐ Sometimes

Do you smoke or vape:

- ☐ No
- ☐ Yes, _____

Have you driven while texting, high or drunk, or been in a car with a driver who was?

- ☐ No
- ☐ Yes, _____

Menstrual History (only answer if applicable)
Have you started your period? If yes, when:

- ☐ No
- ☐ Yes, _____

Is your period approximately every 4 weeks?

- ☐ No _____
- ☐ Yes

Do you have cramps with your period?
(if yes, do you take medication and which):

- ☐ No
- ☐ Yes, _____

Do you have any other symptoms with your period?
(i.e. nausea, vomiting, headaches, mood swings)

- ☐ No
- ☐ Yes, _____