McKenzie Pediatrics
Adolescent Girl's Health Questionnaire

Confidentiality Statement:

Anything you tell me on this form will be kept confidential unless I think there is a risk to your, or someone else's safety. Should that happen, I promise to let you know, and you and I together will figure out how to tell your parents. I will never pass on information to someone else behind your back.

Your Home Environment:

1. Who all lives at home? _____
2. Do your parents get along? • Yes • No
3. Could things be better at home? • No • Yes _____
4. Have you ever run away? • No • Yes _____
5. Do your parents help with schoolwork? • Yes • No _____
6. Does either parent abuse alcohol or drugs? • No • Yes _____
7. Have there been any major recent changes? • No • Yes _____
8. Are there any guns accessible at home? • No • Yes _____

School:

1. Do you get good grades? • Yes • No _____
2. What are your favorite & least favorite subjects? _____
3. Do you miss more than 2 days a month? • No • Yes _____
4. Have you ever failed a class? • No • Yes _____
5. Are you thinking about dropping out? • No • Yes _____
6. Do you receive any tutoring or counseling? • No • Yes _____
7. What do you want to be when you grow up? _____

Your Activities:

1. What do you like to do for fun? _____
2. Do you have a boyfriend or girlfriend? • No • Yes _____
3. Do you have a best friend? • Yes • No _____
4. Do any of your friends smoke or drink? • No • Yes _____
5. Do any of your friends do hard drugs? • No • Yes _____
6. What are your hobbies? _____
7. Do you exercise or play sports? • Yes • No _____
8. Do you watch too much TV/video games? • No • Yes _____
9. Are you employed? • No • Yes _____
10. Have you ever been arrested? • No • Yes _____
11. Do you have a driving permit/license? • No • Yes _____
12. Have you ever driven after drinking? • No • Yes _____

13. Do you date a lot of people? • No • Yes _____
14. Have you ever had unprotected sex? • No • Yes _____
15. Have you ever been forced into sex? • No • Yes _____
16. Do you use contraception? • No • Yes _____
17. Have you ever had an abortion? • No • Yes _____

Drugs:

1. Have you ever Vaped, Juuled, smoked, chewed tobacco, or used alcohol or marijuana? (circle if you've tried or are using)
2. Have you ever felt the need to cut down on your use? • Yes • No
3. Have others annoyed you by commenting on your use? • Yes • No
4. Have you ever felt guilty about your use? • Yes • No
5. Have you ever needed to drink or use a drug before going to school? • Yes • No

Your Body:

1. Circle any of the following that are troubling you:
   vaginal discharge — painful urination — frequent urination
   irregular periods — painful periods — pain mid-cycle
   unusual odors — external rashes — vaginal itching
2. Have you had any known exposure to a sexually transmitted disease? • No • Yes _____
3. Are you worried that you might be pregnant? • No • Yes _____
4. How old were you when you first started having periods? _____