



Guidelines for Adolescent Preventive Services

Parent/Guardian Questionnaire

Confidential

(Your answers will not be given out.)

Date _____

Adolescent's name _____ Adolescent's birthday _____ Age _____

Parent/Guardian name _____ Relationship to adolescent _____

Your phone number: Home _____ Work _____

Adolescent Health History

1. Is your adolescent allergic to any medicines?
 Yes No If yes, what medicines? _____

2. Please provide the following information about medicines your adolescent is taking.

Name of medicine	Reason taken	How long taken
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Has your adolescent ever been hospitalized overnight?
 Yes No If yes, give the age at time of hospitalization and describe the problem.

Age	Problem
_____	_____
_____	_____

4. Has your adolescent ever had any serious injuries?
 Yes No If yes, please explain. _____

5. Have there been any changes in your adolescent's health during the past 12 months?
 Yes No If yes, please explain. _____

6. Please check (✓) whether your adolescent ever had any of the following health problems:
 If yes, at what age did the problem start:

	Yes	No	Age		Yes	No	Age
ADHD/learning disability	<input type="checkbox"/>	<input type="checkbox"/>	_____	Headaches/migraines	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies/hayfever	<input type="checkbox"/>	<input type="checkbox"/>	_____	Low iron in blood (anemia)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bladder or kidney infections	<input type="checkbox"/>	<input type="checkbox"/>	_____	Rheumatic fever or heart disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood disorders/sickle cell anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____	Scoliosis (curved spine)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Seizures/epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chicken pox	<input type="checkbox"/>	<input type="checkbox"/>	_____	Severe acne	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stomach problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tuberculosis (TB)/lung disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	Mononucleosis (mono)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emotional disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis (liver disease)	<input type="checkbox"/>	<input type="checkbox"/>	_____				

7. Does this office or clinic have an up-to-date record of your adolescent's immunizations (record of "shots")?
 Yes No Not sure

Family History

8. Some health problems are passed from one generation to the next. Have you or any of your adolescent's *blood* relatives (parents, grandparents, aunts, uncles, brothers or sisters), living or deceased, had any of the following problems? If the answer is "Yes," please state the age of the person when the problem occurred and his or her relationship to your adolescent.

	Yes	No	Unsure	Age at Onset	Relationship
Allergies/asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Birth defects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Blood disorders/sickle cell anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

	Yes	No	Unsure	Age at Onset	Relationship
Cancer (type _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Drinking problem/alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Drug addiction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Endocrine/gland disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart attack or stroke <i>before</i> age 55	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart attack or stroke <i>after</i> age 55	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Learning disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Mental health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Mental retardation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Seiures/epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Tuberculosis/lung disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

9. With whom does the adolescent live most of the time? (Check all that apply.)

- | | | |
|---|--|---|
| <input type="checkbox"/> Both parents in same household | <input type="checkbox"/> Stepmother | <input type="checkbox"/> Sister(s)/ages _____ |
| <input type="checkbox"/> Mother | <input type="checkbox"/> Stepfather | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Father | <input type="checkbox"/> Guardian | <input type="checkbox"/> Alone |
| <input type="checkbox"/> Other adult relative | <input type="checkbox"/> Brother(s)/ages _____ | |

10. In the past year, have there been any changes in your family? (Check all that apply.)

- | | | | |
|-------------------------------------|---|--|--------------------------------------|
| <input type="checkbox"/> Marriage | <input type="checkbox"/> Loss of job | <input type="checkbox"/> Births | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Separation | <input type="checkbox"/> Move to a new neighborhood | <input type="checkbox"/> Serious illness | |
| <input type="checkbox"/> Divorce | <input type="checkbox"/> A new school or college | <input type="checkbox"/> Deaths | |

Parental/Guardian Concerns

11. Please review the topics listed below. Check (✓) if you have a concern about your adolescent.

	Concern About My Adolescent		Concern About My Adolescent
Physical problems	<input type="checkbox"/>	Guns/weapons	<input type="checkbox"/>
Physical development	<input type="checkbox"/>	School grades/absences/dropout	<input type="checkbox"/>
Weight	<input type="checkbox"/>	Smoking cigarettes/chewing tobacco	<input type="checkbox"/>
Change of appetite	<input type="checkbox"/>	Drug use	<input type="checkbox"/>
Sleep patterns	<input type="checkbox"/>	Alcohol use	<input type="checkbox"/>
Diet/nutrition	<input type="checkbox"/>	Dating/parties	<input type="checkbox"/>
Amount of physical activity	<input type="checkbox"/>	Sexual behavior	<input type="checkbox"/>
Emotional development	<input type="checkbox"/>	Unprotected sex	<input type="checkbox"/>
Relationships with parents and family	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>
Choice of friends	<input type="checkbox"/>	Sexual transmitted diseases (STDs)	<input type="checkbox"/>
Self image or self worth	<input type="checkbox"/>	Pregnancy	<input type="checkbox"/>
Excessive moodiness or rebellion	<input type="checkbox"/>	Sexual identity (heterosexual/homosexual/bisexual)	<input type="checkbox"/>
Depression	<input type="checkbox"/>	Work or job	<input type="checkbox"/>
Lying, stealing, or vandalism	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>
Violence/gangs	<input type="checkbox"/>		

12. What seems to be the greatest challenge for your teen? _____

13. What is it about your teen that makes you proud of him or her? _____

14. Is there something on your mind that you would like to talk about today?
 What is it? _____

15. Can we share your answers to Question 13 with your teen? Yes No