Teen Questionnaire

Name _____
Birth date _____
Date _____

Do You:	**Yes**	**No**
1. See the dentist at least once a year?	□	□
2. Drink milk or eat yogurt or cheese at least 3 times each day?	□	□
3. Eat at least 5 servings of fruit or vegetables each day?	□	□
4. Try to limit the amount of fried or fast foods that you eat?	□	□
5. Exercise or play an active sport 5 days a week?	□	□
6. Feel safe?	□	□
7. Always wear a seat belt when riding in a car?	□	□
8. Always wear a helmet when riding a bike or skateboard?	□	□
9. Receive health care from anyone besides a medical doctor (such as an acupuncturist, herbalist, curandero, or other healer)?	□	□
10. Think you need to lose or gain weight?	□	□
11. Feel stressed out or under a lot of pressure?	□	□
12. Ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?	□	□
13. Spend time in a home where a gun is kept?	□	□
14. Spend time in a home with anyone who smokes?	□	□
15. Often spend time outdoors without sunscreen or other protection such as a hat or shirt?	□	□
Do You Ever:		
16. Smoke cigarettes? Have you ever tried cigarettes?	□	□
17. Use chewing tobacco, snuff, or dip?	□	□
18. Drink alcohol, such as beer, wine, wine coolers, or liquor?	□	□
19. Drive a car after drinking or ride in a car driven by someone who has been drinking?	□	□
20. Use drugs such as marijuana, cocaine, crack, crank, or ecstasy?	□	□
Have you ever had sex?	□	□
If "yes" continue to next question. If "no," go to question 26.		
21. Do you think you or your partner could be pregnant?	□	□
22. Have you had sex without using birth control in the last year?	□	□
23. Do you think you or your partner could have a sexually transmitted disease?	□	□
24. Have you or your partner had sex with any other people in the past year?	□	□
25. Did you or your partner use a condom the last time you had sex?	□	□
Have you:		
26. Ever been forced or pressured to have sex?	□	□
27. Ever been hit, slapped, kicked, or physically hurt by someone?	□	□
28. Ever carried a gun, knife, club, or other weapon?	□	□
FEMALES ONLY		
29. Have you ever had a menstrual period?	□	□

30. How old were you when you had your first period? _____
31. How many periods have you had in the last 12 months? _____
32. **Do you have other questions or concerns about your health?** _____

_____

_____

If you are planning on participating in competitive sports please fill out the questions on the back.

If you are planning on participating in competitive sports please fill out the following questions.

	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	□	□
2. Do you have an ongoing medical condition (like diabetes, asthma or allergies)?	□	□
3. Are you currently taking any prescription or nonprescription medicines or pills?	□	□
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	□	□
5. Have you ever passed out or nearly passed out DURING exercise?	□	□
6. Have you ever passed out or nearly passed out AFTER exercise?	□	□
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	□	□
8. Does your heart race or skip beats during exercise?	□	□
9. Has a doctor ever told you that you have (check all that apply)		
□ High Blood Pressure □ A heart murmur		
□ High Cholesterol □ A heart infection		
10. Has a doctor ever ordered a test for your heart (for example, ECG, echocardiogram)?	□	□
11. Has anyone in your family died for no apparent reason?	□	□
12. Does anyone in your family have a heart problem?	□	□
13. Has any family member or relative died of heart problems or of sudden death before age 50?	□	□
14. Does anyone in your family have Marfan syndrome?	□	□
15. Have you ever spent the night in a hospital?	□	□
16. Have you ever had surgery?	□	□
17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis that caused you to miss a practice of game?	□	□
18. Have you ever had any broken or fractured bones or dislocated joints or stress fractures?	□	□
19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches?	□	□
20. Have you ever been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	□	□
21. Do you regularly use a brace or assistive device?	□	□
22. Do you cough, wheeze, or have difficulty breathing during or after exercise?	□	□
23. Is there anyone in your family who has asthma?	□	□
24. Have you ever used an inhaler or taken asthma medication?	□	□
25. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	□	□
26. Have you had infectious mononucleosis (mono) within the last month?	□	□
27. Do you have any rashes, pressure sores, or other skin problems?	□	□
28. Have you had a herpes skin infection?	□	□
29. Have you ever had a head injury or concussion?	□	□
30. Have you been hit in the head and been confused or lost your memory?	□	□
31. Have you ever had a seizure?	□	□
32. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	□	□
33. Have you ever been unable to move your arms or legs after being hit or falling?	□	□
34. When exercising in the heat, do you have severe muscle cramps or become ill?	□	□
35. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	□	□
36. Have you had any problems with your eyes or vision?	□	□
37. Do you wear glasses or contact lenses?	□	□
38. Do you wear protective eyewear, such as goggles or a face shield?	□	□