Adolescent/Teen Health Screening Form

COLUMBIA GORGE FAMILY MEDICINE

1750 12th Street
Hood River, OR 97031

Phone: 541-386-5070
Fax: 541-386-7190
Web: www.cgfm.com

Date: _____ (mm/dd/yyyy) **Birthdate:** _____ (mm/dd/yyyy)

Name: _____ (last name, first name, middle initial)

General Health

What do you do for exercise? _____

Are you happy with your physical appearance and the shape of your body? ☐ No ☐ Yes

Have you tried to lose weight or control your weight? ☐ No ☐ Yes

School and Work

If you are in school, what grade are you in? _____

Do you like school? ☐ No ☐ Yes

Do you have any concerns about your performance in school? ☐ No ☐ Yes

Do you work? ☐ No ☐ Yes

If so, what do you do? _____

About how many hours do you work each week? _____

Sexual Health

Have you EVER been sexually active? ☐ No ☐ Yes

If so, what are you using to prevent pregancy (check one)? ☐ Nothing

☐ Withdrawal ☐ Condoms/film ☐ Spermacide ☐ Implant ☐ IUD

☐ Birthcontrol Pills ☐ Patch ☐ Depo-Provera ☐ Nuva ring ☐ Emergency pill

Have you ever had a sexually transmitted disease, for example, Chlamydia, Herpes, Gonorrhea, or genital warts? ☐ No ☐ Yes

Tobacco Use

Do you currently smoke tobacco cigarettes or cigars? ☐ No ☐ Yes

If so, how much tobacco per week do you consume? _____

Do you use any other tobacco products (chew, e-cigarettes, hookah, etc.)? ☐ No ☐ Yes

Personal Habits

During the **past 12 months**, did you:

1. Drink any alcohol (more than a few sips)? Do not count sips of alcohol taken during family or religious events. ☐ No ☐ Yes

2. Smoke any marijuana or hashish? ☐ No ☐ Yes

3. Use anything else to get high? (Anything else includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff." ☐ No ☐ Yes

Feelings

In the last 2 weeks, have you felt down, depressed, or hopeless? ☐ No ☐ Yes

In the last 2 weeks, have you felt little interest or pleasure in doing things? ☐ No ☐ Yes

PLEASE FILL OUT BOTH SIDES

Adolescent/Teen Review of Systems

COLUMBIA GORGE FAMILY MEDICINE

1750 12th Street
Hood River, OR 97031

Phone: 541-386-5070
Fax: 541-386-7190
Web: www.cgfm.com

Date: _____ **Birthdate:** _____
(mm/dd/yyyy) (mm/dd/yyyy)

Name: _____
(last name, first name, middle initial)

Last **Dental** examination: _____ Last **Vision** examination: _____

General symptoms	None	Fever	Night sweats	Weight loss	Weight gain	Increased fatigue	
Head & Eyes	None	Eye pain	Headache	Loss of vision	Need glasses/ contacts		
Ear, Nose, & Throat	None	Ear pain	Allergies	Sinusitis	Hearing loss	Snoring	Daytime sleepiness
Cardio-vascular	None	Chest pain	Shortness of breath	Racing or irregular heartbeat	Difficulty breathing with exertion	Swelling of calves/ankles	Calf pain while walking
Respiratory	None	Cough	Coughing up blood	Increased phlegm	Shortness of breath	Wheezing	Asthma
Gastro-intestinal	None	Abdominal pain	Blood in stool or black stool	Loss of stool	Diarrhea or constipation	Nausea, vomiting, or indigestion	Trouble swallowing
Urinary	None	Blood in urine	Loss of urine	Pain with urination	Increased urination	Urinating at night	
Male only	None	Pain or lump in testes	Changes in urinary stream				
Female only	None	Abnormal or painful periods	Painful intercourse	Chronic pelvic pain	Abnormal vaginal discharge	PMS	**Last period:** _____
Musculo-skeletal	None	Muscle weakness	Muscle or joint pain	Morning stiffness	Severe joint pain		
Skin	None	Rash	Non-healing sores	Dry skin	Changes in moles	Acne	
Breast	None	Breast discharge	Breast pain	Breast lump			
Neurologic	None	Fainting	Seizures	Numbness	Dizziness	Tremors	Falls
		Weakness	Trouble walking	Headache	Severe memory problems	Difficulty concentrating	
Psychiatric	Depression	Crying	Poor sleep	Severe anxiety	High stress	Attending counseling	Victim of partner violence
Endocrine	None	Diabetes	Hypothyroid	Hyperthyroid	Hot flashes	Hair loss	Heat or cold intolerance
Hematologic Lymphatic	None	Easy bruising	Swollen lymph glands	Easy bleeding			

PLEASE FILL OUT BOTH SIDES