BAYSHORE PEDIATRICS//(NAME)_____(DATE)_____

You are here for your **ADOLESCENT EXAMINATION**. The following questions will help us discuss any concerns that you may have today. The information on this page is **CONFIDENTIAL** and will not be shared with anyone. This page will be shredded at the end of the visit if that is what you desire. Please be as honest as possible.

PLEASE LIST ANY SPECIFIC CONCERNS YOU WOULD LIKE TO DISCUSS TODAY:

_____

_____

_____

Does anyone in your household or close to you suffer from substance abuse, domestic violence _____ YES_____NO_____
or 1mental illness? (circle)

On average, how many hours a day are you on the computer, texting, & playing video games ?_____

How do you protect yourself on line ?_____

Do you ever use drugs ?_____ YES_____NO_____
Do you ever use alcohol ?_____ YES_____NO_____
Do you smoke or chew tobacco ? If yes, how much?_____ YES_____NO_____

Do you engage in oral sex ? _____ YES_____NO_____
Do you engage in vaginal sex ? _____ YES_____NO_____
Do you engage in anal sex ? _____ YES_____ NO_____
If yes, what do you use to protect against sexually transmitted diseases?_____
Would you like to be tested for sexually transmitted diseases today ?_____ YES_____NO_____
Are you interested sexually in: Guys? Girls? Both? Not sure ? (circle)

Have you ever had anyone at home, school, or elsewhere, make you feel afraid, threatened or
hurt you either physically or sexually ? _____ YES_____NO_____

How many hours of sleep per night do you usually get ?_____