YOUNG ADULT QUESTIONNAIRE

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Name:_____DOB_____AGE_____
What is the reason for your visit today?_____
Are you having any trouble with your menstrual cycle?_____
How often do you get your period?_____
How many days does it last? _____
On your heaviest day, how often do you need to change your pad or tampon?_____
What was the first day of your last period? _____

GENERAL HEALTH

Do you have any concerns about the shape or size of your body?	YES		NO	
Do you want to gain or lose weight?	GAIN	LOSE	STAY	THE SAME
Have you ever tried to lose weight by throwing up, diet pills, laxatives	YES		NO	
Do you skip meals?	YES		NO	
Do you exercise or do a sport at least 5 times a week?	YES		NO	
How many fruit or vegetables do you eat each day?	NONE	1-4	5 or more	
How much milk, yogurt, cheese or ice cream do you eat each day?	_____ servings per day			

SAFETY

Do you wear a seatbelt when you ride in a car?	Always		Sometimes	Never
Does anyone in your house have a gun?	YES		NO	
If yes, is it locked up when not in use?	YES		NO	
Has anyone touched you in a way that made you feel uncomfortable?	YES		NO	
Has anyone ever forced you to have sex?	YES		NO	
Has anyone ever hurt you physically or emotionally?	YES		NO	

RELATIONSHIPS

Are you going out with anyone?	YES		NO	
Who do you find yourself attracted to sexually?	Guys	Girls	Both	Don't know
Have you ever had vaginal sex with anyone?	YES		NO	
Oral sex?	YES		NO	
Anal sex?	YES		NO	

How many sexual partners do you have currently?_____
How many sexual partners have you had in the last year?_____
How old were you when you first had sex?_____

Do you use anything to prevent pregnancy?	YES		NO	
Does your partner use a condom?	YES		NO	

Have you ever been diagnosed with: HPV Chlamydia Trichomonas Herpes
Gonorrhea Syphilis Hepatitis (Circle all that apply)

TOBACCO, ALCOHOL and DRUGS

Have you ever smoked or chewed tobacco?	YES	NO
Have you ever consumed an alcoholic beverage?	YES	NO
How much alcohol do you drink at one time?_____		
Do you ever drink more than 5 drinks in a row?	YES	NO
In the last year, have you ever been in a car when the driver had been drinking or using drugs?	YES	NO
Have you ever driven a car after drinking or using drugs?	YES	NO
Have you ever used marijuana, cocaine, crack, heroin, ecstasy or sniffed inhalants? (circle drugs that you have tried)	YES	NO

MOODS AND EMOTIONS

Have you often felt sad, down or that you had nothing to look forward to?	YES	NO
Have you ever seriously thought about killing yourself?	YES	NO
During the past year, have you had any changes in your life, good or bad?	YES	NO

Describe the changes:_____
_____
_____

LIST ALL MEDICATIONS AND SUPPLEMENTS THAT YOU TAKE

Name_____Dose/Frequency_____
Name_____Dose/Frequency_____
Name_____Dose/Frequency_____
Name_____Dose/Frequency_____
Name_____Dose/Frequency_____

Is there anything that you would like to discuss with the doctor today?

_____
_____
_____
_____
_____