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	☐	☐	_____	Headaches/migraines	☐	☐	_____
Allergies/hayfever	☐	☐	_____	Low iron in blood (anemia)	☐	☐	_____
Asthma	☐	☐	_____	Pneumonia	☐	☐	_____
Bladder or kidney infections	☐	☐	_____	Rheumatic fever or heart disease	☐	☐	_____
Blood disorders/sickle cell anemia	☐	☐	_____	Scoliosis (curved spine)	☐	☐	_____
Cancer	☐	☐	_____	Seizures/epilepsy	☐	☐	_____
Chicken pox	☐	☐	_____	Severe acne	☐	☐	_____
Depression	☐	☐	_____	Stomach problems	☐	☐	_____
Diabetes	☐	☐	_____	Tuberculosis (TB)/lung disease	☐	☐	_____
Eating disorder	☐	☐	_____	Mononucleosis (mono)	☐	☐	_____
Emotional disorder	☐	☐	_____	Other: _____	☐	☐	_____
Hepatitis (liver disease)	☐	☐	_____				

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	☐	☐	☐	_____	_____
Arthritis	☐	☐	☐	_____	_____
Birth defects	☐	☐	☐	_____	_____
Blood disorders/sickle cell anemia	☐	☐	☐	_____	_____

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

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

☐ Both parents in same household
☐ Mother
☐ Father
☐ Other adult relative
☐ Stepmother
☐ Stepfather
☐ Guardian
☐ Brother(s)/ages _____
☐ Sister(s)/ages _____
☐ Other _____
☐ Alone

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

☐ Marriage
☐ Separation
☐ Divorce
☐ Loss of job
☐ Move to a new neighborhood
☐ A new school or college
☐ Births
☐ Serious illness
☐ Deaths
☐ Other _____

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

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