Pediatric and Adolescent Gynecology Clinic Questionnaire

Please complete the following questionnaire prior to your visit to assist us in helping you with your care. Your records will be kept confidential. If you don't feel comfortable answering a question, or do not understand a question, please leave it blank and your doctor or nurse will talk with you about it.

Name: ____________________________ **Age:** _____ **Today's date:** ___________

Pediatrician / Referring Physician Name: __________________________________

What would you like to discuss with the doctor at your clinic visit? ________________

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Family		**For doctor/nurse use**
Who do you live with? (Please circle all that apply.)	Mother Father Guardian Sibling(s): Other:	
Can you talk with your parent(s) or guardian(s) about personal things happening in your life? If no, is there another adult you trust and can talk to if you have a problem?	ق Yes ق No ق Yes ق No Who?	
School and Work		
What school do you go to?	School: ق Not in school	
What grade are you in?	Grade: ق Not in school	
Do you like school and do well in school?	ق Yes ق No ق Not in school	
Do you have a job?	ق Yes ق No Doing what?	

Appearance and Fitness		
Do you have any concerns or questions about the shape or size of your body or the way you look?	ق Yes ق No ق Not sure	
Do you want to lose weight?	ق Gain ق Lose ق Neither	
Do you exercise or play a sport?	ق Yes ق No	
Safety		
Has anyone ever touched you in a way that made you uncomfortable?	ق Yes ق No ق Not sure	
Has anyone ever forced you to have sex?	ق Yes ق No ق Not sure	
Has anyone ever hurt you physically or emotionally?	ق Yes ق No ق Not sure	
Emotions		
In the past few weeks, have you often felt sad and down or as though you have nothing to look forward to?	ق Yes ق No	

Medical History		For doctor/nurse use
Do you have any medical problems?	ق Yes ق No List:	
Do you take any medications?	ق Yes ق No List:	
Do you have any medication or food allergies?	ق Yes ق No List:	
Have you ever been hospitalized?	ق Yes ق No For what?	
Have you ever had any surgeries?	ق Yes ق No What kind?	
Tobacco		
Do you smoke or chew tobacco?	ق Yes ق No How much?	

Menstrual History		
Are you having menstrual periods?	ق Yes ق No	
When was your last period?	Date:	
When did you first get your period?	Age:	
How often do you have your period?	Every:	
Do you have pain with your periods?	ق Yes ق No	
Pelvic Pain History		
Do you have pelvic pain?	ق Yes ق No	
With bowel movements?	ق Yes ق No	
With urination?	ق Yes ق No	
How many days per month do you have pain?		
On a 1-10 scale, what number is your worst pain?		
What relieves your pain?		

Family Medical History		
Please check if anyone in your family has had any of the following medical problems:		
ق Alcohol / Drugs		
ق Anemia		
ق Asthma		
ق Bleeding Disorder		
ق Blood Clot		
ق Cancer		
ق Depression		
ق Diabetes		
ق Eating Disorder		
ق Endocrine Disorder		
ق Endometriosis		
ق Heart Disease		
ق High Blood Pressure		
ق Kidney Disease		
ق Liver Disease / Hepatitis		
ق Obesity		
ق Seizure Disorder		
ق Thyroid Disorder		