Previsit Questionnaire for Adolescents

Do you forget things unless you write them down? Here is a list of common problems to help you remember what you want to talk about during your next meeting with your doctor. Please give this sheet to your doctor at the beginning of your visit.

Many of these topics are very personal, and you may want to keep your list private. If you want the list back the doctor will return it to you after looking at it. You can throw it out, destroy it, or take it home after your visit. If you choose to let your doctor keep the questionnaire feel assured that your list will stay private with us.

These are some health problems young people sometimes have. Please check all those you are experiencing:

- ☐ Trouble sleeping
- ☐ Feel tired all the time
- ☐ Dizziness/Fainting
- ☐ Nausea/vomiting
- ☐ Diarrhea/constipation
- ☐ Worries about your health
- ☐ Worries about your eating Habits
- ☐ Wetting the bed
- ☐ Discharge from penis or vagina
- ☐ Headaches
- ☐ Stomachaches
- ☐ Chest pain/Trouble breathing
- ☐ Other pains
- ☐ Menstruation (Period) Problems

Sexual feelings are a normal part of growing up, but a lot of young people have worries and questions about sex. Place a checkmark below next to all those that you wonder about or have concerns or worries about:

- ☐ How to know when sex is right for you
- ☐ Sexually transmitted diseases
- ☐ HIV – AIDS
- ☐ Birth Control or How to keep from becoming a parent too soon
- ☐ Being gay or lesbian
- ☐ Wet Dreams
- ☐ Your Breasts or Vagina/ Penis or Testicles

Some young people don't like the way they look. Do you think you are…? (Check the ones that apply):

- ☐ Too short
- ☐ Too thin
- ☐ Too Tall
- ☐ Too fat
- ☐ Too ugly

Are you worried about or troubled by …?

- ☐ Acne
- ☐ Self-mutilation (e.g., cutting/hitting/burning yourself)
- ☐ Bullying/Violence/Your Safety
- ☐ Other things _____
- ☐ Falling school grades

Many young people have been abused physically, sexually, or emotionally. Has this happened to you or a friend?

☐ Yes ☐ No

Many young people experiment with alcohol or drugs (e.g., pot, grass, Ecstasy). Have you or any of your close friends tried alcohol or drugs?

☐ Yes ☐ No

Would you like some answers about alcohol or drugs?

☐ Yes ☐ No

I am worried or upset about how my boyfriend or girlfriend or friend treats me.

☐ Yes ☐ No

I am worried about my parents' relationship with each other.

☐ Yes ☐ No

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My relationship with my mother would be better if

My relationship with my father would be better if

I often feel:

☐ Lonely

☐ Sad

☐ Like I don't get any fun out of life

☐ Like dying or killing myself

☐ Angry or irritable

☐ Anxious or nervous

☐ Yes, I would you like to get counseling about something I have on my mind.

In the following space please write about any other problems we forgot to ask you about

Remember: If you are 14 years of age or older our discussions with you are private. We hope you will feel free to talk openly with us. Information is not shared with other people without your permission unless we are concerned that you are in immediate danger of seriously harming yourself or someone else.

Please understand that you were asked to come to our clinic 30 minutes ahead of the time you are scheduled to meet the doctor. This was done to be sure that you completed the registration and questionnaire in time.

Although we try our best to be on time, it may happen that your doctor will be late in meeting with you. This is not because you will be forgotten. If the doctor is late it is usually because he or she was finishing caring for the patient before you. When you will be met the doctor will give you the time that is needed to care for you too. Thank you for your patience and understanding.

HERZL FAMILY PRACTICE CENTRE- TEEN CONTACT INFORMATION SHEET

We may need to contact you to arrange an appointment, cancel an appointment, or send you a letter. By giving us the following contact information it will help us ensure your confidentiality.

Name _____
(Last) (First)

Mailing Address (If we need to mail something to you, where do you want it sent?)

_____

_____

_____

Can we send a letter home to you? (circle one) **Yes No**

Please write the phone numbers and/or email address where you allow us to contact you:

1) Home: _____

Can we leave a discrete message with someone at home? (circle one) **Yes No**

Can we leave a discrete message on your home phone voicemail? (circle one) **Yes No**

If your parent answers, can we say we are calling from the Herzl Clinic? **Yes No**

Any restrictions? _____

2) Cell: _____

Can we leave a message on your cell phone? (circle one) **Yes No**

Any restrictions? _____

3) Work: _____

Can we leave a discrete message with someone at work? (circle one) **Yes No**

Can we leave a discrete message on your answering machine? (circle one) **Yes No**

Any restrictions? _____

4) Other number (s): _____

Can we leave a discrete message with someone there? (circle one) **Yes No**

Can we leave a discrete message on that answering machine? (circle one) **Yes No**

Any restrictions? _____

5) Email: _____

Are there any other restrictions that we should be aware of when contacting you? If so, please provide details.

_____

_____