CONFIDENTIAL INFORMATION

18-21 YEAR OLD FEMALES:

PATIENTS complete the section below and HAND TO THE NURSE when you have completed the form. This form will be shredded after the doctor has read the form.

Do you have any concerns about…

1. Do you have any school concerns (circle one) such as poor grades, lack of motivation, loss of interest, difficulty concentrating, completing assignments, behavior, or excessive absences from school? ☐ Yes ☐No
2. Do you have any concerns about your weight? ☐ Yes ☐No
3. Do you have any body piercings (other than earrings) or tattoos? ☐ Yes ☐No
4. In the past year have you tried to lose weight by vomiting, taking pills, laxatives, or starving yourself? ☐ Yes ☐No
5. Do you have any concerns about (circle) your breasts, menstruation, pelvic pain, vaginal lesions (sores) or vaginal discharge? ☐ Yes ☐No
6. Are you sexually active now? ☐ Yes ☐No

If you answered yes above, please answer the questions below:

- Does your partner always use a condom? ☐ Yes ☐No
- Have you ever been pregnant? ☐ Yes ☐No
- Do you have any children? ☐ Yes ☐No
- Have you ever had an abortion? ☐ Yes ☐No
- Have you ever been treated for a sexually transmitted disease? ☐ Yes ☐No
- Are you taking oral contraceptives? ☐ Yes ☐No
- Are you interested in starting oral contraceptives? ☐ Yes ☐No

7. Do you have any concerns about inappropriate sexual behavior, or sexual orientation? ☐ Yes ☐No
8. Have you ever been physically or sexually mistreated or abused? ☐ Yes ☐No
9. Do you have any social concerns: (lack of friends, poor relationships)?, ☐ Yes ☐No
10. Do you have any behavioral concerns: (temper outbursts, risk taking)? ☐ Yes ☐No
11. Do you smoke cigarettes? ☐ Yes ☐No
12. Do you ever use marijuana, cocaine, inhalants, steroids, other? ☐ Yes ☐No
13. Do you have concerns that you may not graduate from High School? ☐ Yes ☐No
14. Do you drink alcohol? ☐ Yes ☐No

    If yes, do you drink (circle all that apply): Beer Wine Liquor
    How often? Daily Weekly Rarely _____# of drinks
15. Have you been drunk in the past month? ☐ Yes ☐No
16. Do you ever drive a vehicle when you have been drinking alcohol? ☐ Yes ☐No
17. Do you always use a safety belt when riding in a car? ☐ Yes ☐No
18. Does anyone have a gun in your home? ☐ Yes ☐No
19. Do you exercise regularly? ☐ Yes ☐No
20. How many ounces of milk do you drink in a day? _____ What kind of milk? _____
21. How many cups of soda/juice/energy drinks do you drink in a day?_____

Patient lives with: Mom _____ Dad _____ Both Together _____ Both Separately _____ At College _____

Do you have any concerns you wish to discuss? ☐ Yes ☐No

_____

_____

Patient Health Questionnaire-2

Name: _____ Date: _____

Over the past 2 weeks, how often have you been bothered by any of the following problems:

- **Little interest or pleasure in doing things**

  0 = Not at all

  1 = Several days

  2 = More than half the days

  3 = Nearly every day

- **Feeling down, depressed, or hopeless**

  0 = Not at all

  1 = Several days

  2 = More than half the days

  3 = Nearly every day

Adapted from the AAP Bright Futures Tool Kit