CONFIDENTIAL INFORMATION

16-17 YEAR OLD MALES:

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.

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. Are you sexually active now? ☐ Yes ☐No

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

Do you always use a condom? ☐ Yes ☐No
Have you ever been treated for a sexually transmitted disease? ☐ Yes ☐No
Do you have any discharge from your penis? ☐ Yes ☐No

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

14. Have you been drunk in the past month? ☐ Yes ☐No
15. Do you ever drive a vehicle when you have been drinking alcohol? ☐ Yes ☐No
16. Do you always use a safety belt when riding in a car? ☐ Yes ☐No
17. Does anyone have a gun in your home? ☐ Yes ☐No
18. Do you exercise regularly? ☐ Yes ☐No
19. How many ounces of milk do you drink in a day? _____ What kind of milk? _____
20. How many cups of soda/juice/energy drinks do you drink in a day? _____

Please tell us the names and ages of your brothers and sisters

_____

_____

Patient lives with: Mom_____ Dad_____ Both Together_____ Both Separately_____

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