

Teen Questionnaire

Name _____

Birth date _____

Date _____

Do You:

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. See the dentist at least once a year? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Drink milk or eat yogurt or cheese at least 3 times each day? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Eat at least 5 servings of fruit or vegetables each day? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Try to limit the amount of fried or fast foods that you eat? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Exercise or play an active sport 5 days a week? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Feel safe? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Always wear a seat belt when riding in a car? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Always wear a helmet when riding a bike or skateboard? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Receive health care from anyone besides a medical doctor (such as an acupuncturist, herbalist, curandero, or other healer)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Think you need to lose or gain weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Feel stressed out or under a lot of pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Spend time in a home where a gun is kept? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Spend time in a home with anyone who smokes? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Often spend time outdoors without sunscreen or other protection such as a hat or shirt? | <input type="checkbox"/> | <input type="checkbox"/> |

Do You Ever:

- | | | |
|--|--------------------------|--------------------------|
| 16. Smoke cigarettes? Have you ever tried cigarettes? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Use chewing tobacco, snuff, or dip? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Drink alcohol, such as beer, wine, wine coolers, or liquor? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Drive a car after drinking or ride in a car driven by someone who has been drinking? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Use drugs such as marijuana, cocaine, crack, crank, or ecstasy? | <input type="checkbox"/> | <input type="checkbox"/> |

Have you ever had sex?

If "yes" continue to next question. If "no," go to question 26.

- | | | |
|---|--------------------------|--------------------------|
| 21. Do you think you or your partner could be pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Have you had sex without using birth control in the last year? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Do you think you or your partner could have a sexually transmitted disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Have you or your partner had sex with any other people in the past year? | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Did you or your partner use a condom the last time you had sex? | <input type="checkbox"/> | <input type="checkbox"/> |

Have you:

- | | | |
|--|--------------------------|--------------------------|
| 26. Ever been forced or pressured to have sex? | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Ever been hit, slapped, kicked, or physically hurt by someone? | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Ever carried a gun, knife, club, or other weapon? | <input type="checkbox"/> | <input type="checkbox"/> |

FEMALES ONLY

- | | | |
|--|--------------------------|--------------------------|
| 29. Have you ever had a menstrual period? | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. How old were you when you had your first period? _____ | | |
| 31. How many periods have you had in the last 12 months? _____ | | |
| 32. Do you have other questions or concerns about your health? _____ | | |

If you are planning on participating in competitive sports please fill out the questions on the back.

If you are planning on participating in competitive sports please fill out the following questions.

	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have an ongoing medical condition (like diabetes, asthma or allergies)?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently taking any prescription or nonprescription medicines or pills?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever passed out or nearly passed out DURING exercise?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever passed out or nearly passed out AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
8. Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
9. Has a doctor ever told you that you have (check all that apply)		
<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> A heart murmur		
<input type="checkbox"/> High Cholesterol <input type="checkbox"/> A heart infection		
10. Has a doctor ever ordered a test for your heart (for example, ECG, echocardiogram)?	<input type="checkbox"/>	<input type="checkbox"/>
11. Has anyone in your family died for no apparent reason?	<input type="checkbox"/>	<input type="checkbox"/>
12. Does anyone in your family have a heart problem?	<input type="checkbox"/>	<input type="checkbox"/>
13. Has any family member or relative died of heart problems or of sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>
14. Does anyone in your family have Marfan syndrome?	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis that caused you to miss a practice of game?	<input type="checkbox"/>	<input type="checkbox"/>
18. Have you ever had any broken or fractured bones or dislocated joints or stress fractures?	<input type="checkbox"/>	<input type="checkbox"/>
19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches?	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you ever been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	<input type="checkbox"/>	<input type="checkbox"/>
21. Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>
22. Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
23. Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>
24. Have you ever used an inhaler or taken asthma medication?	<input type="checkbox"/>	<input type="checkbox"/>
25. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>
26. Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
27. Do you have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
28. Have you had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>
29. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>
30. Have you been hit in the head and been confused or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>
31. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
32. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
33. Have you ever been unable to move your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
34. When exercising in the heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/>	<input type="checkbox"/>
35. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>
36. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
37. Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
38. Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>