TORRANCE MEMORIAL
PHYSICIAN NETWORK

ADOLESCENT PHYSICAL HEALTH QUESTIONNAIRE

Please update any changes that have occurred in the last year.

Name: _____ Today's Date: _____ Date of Birth: _____

Changes in Medications? ☐Yes ☐ No

(New medications prescribed since your last visit or changes in dosage. Please list any medications that you are taking including over-the-counter medications, vitamins, laxatives and herbal supplements.)

Medication Name:	Dose:	Taken How/How Often?	Who Prescribed This?

Allergies? ☐ Yes ☐ No Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____

Past Medical and Surgical History: (Please list most recent first)

Surgery	Year	Hospitalization	Year

Your Specialists: (Please list those you currently see or have seen)

Name	Specialty	Name	Specialty

Immediate Family History: (Please note the following diseases: Cancer, Diabetes, High Blood Pressure, Heart Trouble, Stroke, Seizures, Thyroid Disorder, Mental Disorders, Asthma, Osteoporosis, Tuberculosis.)

Family:	Age (if living)	Deceased: (note age and cause)	Healthy or noted Illness(es):	Additional Siblings with age and condition:
Father:				
Mother:				
Brother:				
Brother:				
Sister:				
Sister:				

☐ ***Please check if you have written additional information on the back of the page.***

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Name: _____ Today's Date: _____ Date of Birth: _____

Social History

Preferred Language: _____ Need Interpreter? ☐ Yes ☐ No

Grade in School: _____ Currently Employed: ☐Yes ☐ No

Occupation: _____ Hours worked per week: _____

Is your school/work satisfying and free from undue pressure or stresses? ☐Yes ☐ No

Do you miss much time from school/work? ☐Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
# of Previous Marriages: _____

How is your relationship with your parents? _____

How is your relationship with your siblings? _____

Are you sexually active? ☐Yes ☐ No

Do you give or receive ongoing care at home? ☐Yes ☐ No To or from whom? _____

Smoking: ☐ Never ☐ Yes, # of Packs/Day: _____
☐ Former # of Years Smoked: _____

Alcohol: ☐ Never ☐ Yes, # of Drinks/Week: _____
☐ Former Type: _____

Illicit Drugs: ☐ Never ☐ Yes
☐ Former Type: _____

Caffeine Intake: ☐ Yes ☐ No
☐ Coffee ☐ Tea ☐ Soda ☐ Energy Drink ☐ Chocolate Daily Intake: _____

Lifestyle: Are you on a specific diet? ☐Yes ☐ No If yes, which type of diet? _____

Do you exercise regularly? ☐Yes ☐ No If yes, what type of exercise: _____

Number of days per week: _____

Hours per day: _____

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Name: _____ Today's Date: _____ Date of Birth:_____

Please mark any of the following conditions that you may have on a recurrent basis. Answer all questions that apply.

General:
☐ Fatigue
☐ Fever
☐ Chills or night sweats
☐ Weight gain
☐ Weight loss

Head, Eyes, Ears, Nose, Throat:
☐ Eye pain or injury
☐ Itching or eye redness
☐ Vision: Loss/Blurry/Double

☐ Ear pain or discharge
☐ Hearing loss
☐ Ringing in ears/Tinnitus
☐ Dizziness
☐ Fainting spells

☐ Bleeding nose
☐ Runny nose/sneezing/itching
☐ Sinus pressure

☐ Bleeding gums
☐ Sore Throat
☐ Painful swallowing

Neck:
☐ Stiffness or injury
☐ Enlarged glands

Respiratory:
☐ Wheezing
☐ Difficulty breathing
☐ Frequent colds
☐ Chronic or frequent cough
☐ Bloody sputum
☐ Asthma
☐ Seasonal or environmental allergies

Cardiovascular:
☐ Chest pain
☐ Chest pressure
☐ Heart murmur
☐ Palpitations / Heart skips
☐ Shortness of breath w/ exercise
☐ Shortness of breath lying down
☐ Leg cramps or swelling
☐ Varicose veins

Gastrointestinal:
☐ Loss of appetite
☐ Abdominal pain or cramping
☐ Heartburn or indigestion
☐ Intolerance to greasy /spicy food
☐ Vomiting food
☐ Vomiting blood
☐ Constipation
☐ Diarrhea
☐ Nausea
☐ Pain with bowel movements
☐ Blood in stool or black stool
☐ Hemorrhoids

Genitourinary:
☐ Burning or painful urination
☐ Blood in urine
☐ Urine frequency or urgency
☐ Loss of urine w/ cough or sneeze
☐ Decrease in strength of stream
☐ Nighttime urination:
☐ # of times _____

Gynecological (Women Only)**:**
☐ Vaginal discharge
☐ Pain with menstruation
☐ Pain with sexual relations
☐ Age when period started: _____
☐ How long do periods last?_____days
☐ Are periods regular: ☐ Yes ☐ No
☐ Age at menopause: _____
☐ Number of pregnancies: _____
☐ Number of miscarriages: _____
☐ Number of abortions: _____
☐ Number of children: _____
☐ Do you take Folic Acid?☐ Yes ☐ No

Locomotor-Musculoskeletal:
☐ Pain in neck or back
☐ Joint pain or swelling
☐ Muscle pain or weakness
☐ Difficulty walking
☐ Balance problems
☐ Pain while walking

Neuro-Psychiatric:
☐ Seizures ☐ Convulsions
☐ Tremors
☐ Extremity numbness, tingling
☐ Problems with balance or gait
☐ Memory problems
☐ Headaches or migraines
☐ Trouble sleeping ☐ Insomnia
☐ Anxiety
☐ Depression
☐ Suicidal thoughts
☐ Loss of interest
☐ Hallucinations

Hematologic:
☐ Excessive bleeding
☐ Abnormal bruising
☐ Slow to heal after cuts

Skin:
☐ Frequent infections or boils
☐ Hives/eczema/rash
☐ Moles that are changing
☐ Skin Cancer:
☐ Basal cell / ☐ Squamous cell
☐ Melanoma
☐ Keloids
☐ Skin allergies:
Latex or Tape
Other: _____

Endocrine:
☐ Hormone therapy
☐ Hot Flashes
☐ Hot or cold intolerance
☐ Excessive thirst
☐ Change in texture hair or skin

Male Reproductive:
☐ Erectile Dysfunction
☐ Testicular pain or mass
☐ Penile discharge

_____
Date

_____
Patient/Legal Guardian Signature

_____
Provider Signature

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Name: _____ Today's Date: _____ Date of Birth:_____

Depression Screening Test (PHQ-A)

Over the **last two weeks**, how often have you been bothered by any of the following problems?

(Please circle the number that best describes how you have been feeling to indicate your answer)

	Not at all	Several days	More than 1/2 the days	Nearly every day
1. Feeling down, depressed, irritable or hopeless	0	1	2	3
2. Little interest or pleasure in doing things	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Poor appetite, weight loss or over eating	0	1	2	3
5. Feeling tired or having little energy	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things like school work, reading, or watching television	0	1	2	3
8. Moving or speaking so slowly that other people notice. Or the opposite – being so fidgety or restless that you were moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
Add columns:		+	+	
(Add totals for the 3 columns)			**Total**	=

1. In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes? ☐Yes ☐ No

2. Has there been a time in the **past month** when you have had serious thoughts about ending your life? ☐Yes ☐ No

3. Have you **EVER**, in your **WHOLE LIFE**, tried to kill yourself or make a suicide attempt? ☐Yes ☐ No

4. If you checked off any problems, how **difficult** have these problems made it for you to do your work, take care of things at home, or get along with other people? ☐ Not at all ☐ Somewhat difficult ☐ Very Difficult ☐ Extremely difficult

**** If you have had thoughts that you would be better off dead or hurting yourself in some way, please discuss this with your Health Care Provider, go to a hospital emergency room or call 911.*

Alcohol Screening Test

Please mark your answer. Points are posted next to your answer. Add up total at bottom of section.

1. How often do you have a drink containing alcohol?
☐ Never (0.0) ☐ Monthly or less (0.5) ☐ 2-4 times a month (1.0) ☐ 2-3 times a week (1.5) ☐ 4 or more times a week (2.0)

2. How many drinks containing alcohol do you have on a typical day when you are drinking?
☐ 1 or 2 (0.0) ☐ (0.5) 3 or 4 ☐(1.0) 5 or 6 ☐ (1.5) 7 to 9 ☐ (2.0) 10 or more

3. Have people annoyed you by criticizing your drinking?
☐ No (0.0) ☐ Yes (1.0)

4. Have you ever felt bad or guilty about your drinking?
☐ No (0.0) ☐ Yes (1.0)

5. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?
☐ No (0.0) ☐ Yes (1.0)

Score: _____ A score of 2.5 or greater indicates possible misuse and the need for further evaluation. Please fill out the Alcohol Audit Form.

PROVIDER INITIALS _____