Riverdale Pediatrics, P.C.	Name
	Date of birth:

Adolescent/Young Adult Questionnaire

All answers are confidential. Please complete in privacy and give directly to the doctor.			
Do you drink or have you ever had alcohol?	Yes ☐	No ☐	Don't know ☐
Do you smoke (tobacco, hookah, pot)? Chew or snuff tobacco?	Yes ☐	No ☐	Don't know ☐
Do you use or have you ever tried a recreational drug?	Yes ☐	No ☐	Don't know ☐
Do you have friends who drink, smoke or use recreational drugs?	Yes ☐	No ☐	Don't know ☐
Do you use or have you ever used a steroid or performance-enhancing supplement?	Yes ☐	No ☐	Don't know ☐
Do you use or have you ever used a nutritional supplement or protein shake?	Yes ☐	No ☐	Don't know ☐
Have you felt depressed or helpless since your last visit?	Yes ☐	No ☐	Don't know ☐
Have you ever felt like hurting yourself or anyone else?	Yes ☐	No ☐	Don't know ☐
Are you sexually active?	Yes ☐	No ☐	Don't know ☐
If you are sexually active, do you use birth control and protection against sexually transmitted diseases?	Yes ☐	No ☐	Don't know ☐
Have you ever been tested for sexually transmitted diseases?	Yes ☐	No ☐	Don't know ☐
If yes, please give date			
Were any of the tests positive	Yes ☐	No ☐	Don't know ☐
If a test was positive, what was done?			

For girls:

How old were you when you had your first period?			
Are your periods regular?	Yes ☐	No ☐	Don't know ☐
Do the flow and discomfort affect your level of activity?	Yes ☐	No ☐	Don't know ☐
When did your last menstrual period start?			