

Patient Questionnaire (Middle/Older Teen)

Sexual Health

Have any of your close friends ever had sexual intercourse?

- No Yes Not Sure

Have you ever been in a romantic or physical relationship?

- No Yes Not Sure

Do you think you might be gay, lesbian or bisexual?

- No Yes Not Sure

Do you feel safe in your relationships? (explain: _____)

- No Yes Not Sure

What are your thoughts about the right time or situation in your life to enter into a sexual relationship? (answer all that apply)

- Marriage Engaged Long-term committed relationship Other _____
 Meet the right person Now When I'm in love When I'm older (age _____)

What kind of information are you comfortable sharing or talking about with your parents or other important adults?

Anatomy, body changes, and periods

- Mother Father Step-Mother Step-Father Other _____

General Questions about sex, diseases and pregnancy

- Mother Father Step-Mother Step-Father Other _____

Personal information about sexuality, STD's and birth control

- Mother Father Step-Mother Step-Father Other _____

Have you ever had any sexual activity (vaginal intercourse, oral sex, anal sex, etc.)?

- No Yes Not Sure

If YES or NOT SURE: Any Parent or Guardian aware?

- Mother Father Step-Mom Other _____
 No Step-dad

How old were you the first time you had sex (if applies)?

How often do you use condoms when you have sex?

- 100% of the time Sometimes Rarely/Never

When was the last time you had unprotected sex?

- Never Days/Weeks ago Months/years ago

What methods do you use to prevent pregnancy (circle all that apply)?

- Condoms Birth control pills Contraceptive patch Contraceptive vaginal ring Emergency contraception (plan b)
 Withdrawal IUD None Other _____

Boys Stop Here, Girls Only

Gynecologic History	Age of First Period: <input type="radio"/> Not started <input type="radio"/> Age _____
First day of most recent period: ____ / ____ / ____	Periods are usually: <input type="radio"/> Regular <input type="radio"/> Irregular
Cramping is typically: <input type="radio"/> None to mild <input type="radio"/> Mild to moderate <input type="radio"/> Moderate to severe <input type="radio"/> Severe	
Have you ever been pregnant?	<input type="radio"/> No <input type="radio"/> Yes
Have you ever had an abortion or miscarriage?	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Not Sure
Have you ever had a sexually transmitted infection?	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Not Sure
Has anyone ever forced you to have sex you did not want to have?	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Not Sure

May we share these answers with your parents (circle)? Yes No