Youth Health Questionnaire for 12-24 year old

August 2018 V1

This form is to help us get to know more about you. Your privacy is important to us. This information will only be seen by your GP and health care team. After the information has been entered into your digital health record, this piece of paper will be destroyed. Please answer as much as possible. If you need help to fill out this form, please ask the Nurse or Receptionist.

PERSONAL DETAILS

Family Name ☐ Gender ☐ Male ☐ Female ☐ Other

First Name (s) ☐ Date of Birth ☐☐ ☐☐ ☐☐

Preferred Name ☐ Completed by: ☐

PAST MEDICAL HISTORY: √ Have you ever had any of the following?

☐ Skin problem ☐ Nose problem ☐ Lung problem ☐ Liver problem ☐ Kidney problem

☐ Epilepsy ☐ Migraine ☐ Diabetes ☐ Cancer ☐ Bleeding disorder

☐ Mood problem ☐ Bone problem ☐ Rheumatic Fever ☐ Heart problem ☐ Blood clot in leg / lung

☐ Would rather tell the nurse or doctor instead ☐ Other ________________________________

DISABILITIES AND IMPAIRMENTS

✓ Do you have a disability or impairment? E.g. hearing, dyslexia ☐ Yes ☐ No

If yes, please state: ☐

MEDICATION

✓ Do you use any medicine (tablets, inhalers, creams or injections) regularly? ☐ Yes ☐ No

ALLERGIES

✓ Are you allergic to any medicines? ☐ Yes ☐ No

✓ Do you have any other allergies? E.g. strapping tape or food ☐ Yes ☐ No

If yes, please state: ☐

What was your reaction ☐ When ☐

GENERAL HEALTH QUESTIONS

What do you do for leisure activities? ☐ When was the last time? ☐

How many hours sleep do you usually get? ☐ hours

How often do you use a digital screen after 10pm? ☐ Never ☐ Some nights ☐ Every night

SMOKING AND ALCOHOL

✓ Have you ever smoked? ☐ Yes ☐ No Would you like help to quit? ☐ Yes ☐ No

✓ If yes, are you? ☐ A current smoker ☐ Ex-smoker since ___________

✓ Do you vape? ☐ Yes ☐ No

✓ Do you drink alcohol? ☐ Yes ☐ No If yes, how many cans/bottles/glasses per session? ☐

If yes, how often? ☐ Once a month or less ☐ 2 – 4 times a month ☐ 2-3 times a week ☐ 4 or more times a week

✓ How often do you have more than 6 or more glasses per session?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily

FAMILY HISTORY

✓Has any immediate family member (mother, father, brother, sister) had any of these health problems?

☐ Asthma ☐ Mental Illness ☐ Alcohol, meth or other drug problem

☐ Tuberculosis ☐ Diabetes ☐ Cancer ______________________

☐ High Blood Pressure ☐ Stroke ☐ Other ______________________

☐ High Cholesterol ☐ Heart Attack ☐ Would rather tell the nurse or doctor instead

PAST VACCINATION HISTORY

Have you been vaccinated against Tetanus? ☐ No ☐ Yes

Have you had 2MMR (Measles Mumps Rubella) ☐ No ☐ Yes

Have you had 3HPV vaccinations? ☐ No ☐ Yes

Signature: Date: