

Several tools have been designed to support implementing the American Medical Association's (AMA) Guidelines for Adolescent Preventive Services (GAPS) program in your clinical setting. The six forms include the Younger Adolescent Questionnaire in English and Spanish, Middle-Older Adolescent Questionnaire in English and Spanish, and the Parent/Guardian Questionnaire in English and Spanish. The GAPS Recommendations Monograph is also included for your information and reference. The questionnaires and monograph are considered master copies that you can reproduce but not alter, modify, or revise without the expressed written consent of the Child and Adolescent Health Program at the American Medical Association.



Guidelines for Adolescent Preventive Services
Younger Adolescent Questionnaire

Confidential

(Your answers will not be given out.)

Chart# _____

Name _____ Today's Date _____
Last First Middle Initial month day year

Birthdate _____ Grade in School _____ Boy or Girl (*circle one*) Age _____
month day year

Address _____ City _____ State _____ Zip _____

Phone Number _____ Pager/Beeper Number _____
area code

What languages are spoken where you live? _____

Are you: White African-American Asian/Pacific Islander
 Latino/Hispanic Native American Other _____

Medical History

1. Why did you come to the clinic/office today? _____

2. Are you allergic to any medicines?
 No Yes, name of medicine(s): _____ Not Sure

3. Do you have any health problems?
 No Yes, problem(s): _____ Not Sure

4. Are you taking any medicine now?
 No Yes, name of medicine(s): _____ Not Sure

5. Have you been to the dentist in the last year? No Yes Not Sure

6. Have you stayed overnight in a hospital in the last year? No Yes Not Sure

7. Have you ever had any of the problems below?

	Yes	No	Not Sure		Yes	No	Not Sure
Allergies or hay fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis (TB)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

For Girls Only

8. Have you started having periods? No Yes
a. *If yes*, are your periods regular (once a month) ? No Yes
b. *If yes*, what was the 1st day of your last period? Month _____ Day _____
9. Have you ever been pregnant? Yes No

Family Information

10. Who do you live with? (Check all that apply).
 Mother Stepmother Brother(s)/ages _____
 Father Stepfather Sister(s)/ages _____
 Guardian Other adult relative Other/(explain) _____
11. Do you have older brothers or sisters who live away from home? Yes No Not Sure
12. During the past year, have there been any changes in your family such as: (Check all that apply)
 Marriage Loss of job Births Other changes _____
 Separation Moved to a new neighborhood Serious Illness/Injury _____
 Divorce A new school Deaths _____

Specific Health Issues

13. Please check whether you have questions or are worried about any of the following:
- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Height | <input type="checkbox"/> Neck or back | <input type="checkbox"/> Muscle or pain in arms/legs | <input type="checkbox"/> Anger or temper |
| <input type="checkbox"/> Weight | <input type="checkbox"/> Breasts | <input type="checkbox"/> Menstruation or periods | <input type="checkbox"/> Feeling tired |
| <input type="checkbox"/> Eyes or vision | <input type="checkbox"/> Heart | <input type="checkbox"/> Wetting the bed | <input type="checkbox"/> Trouble sleeping |
| <input type="checkbox"/> Hearing or earaches | <input type="checkbox"/> Coughing or wheezing | <input type="checkbox"/> Trouble urinating or peeing | <input type="checkbox"/> Fitting in/belonging |
| <input type="checkbox"/> Colds/runny or stuffy nose | <input type="checkbox"/> Chest pain or trouble breathing | <input type="checkbox"/> Drip from penis or vagina | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Mouth or teeth or breath | <input type="checkbox"/> Stomach ache | <input type="checkbox"/> Wet dreams | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Vomiting or throwing up | <input type="checkbox"/> Skin (rash/acne) | <input type="checkbox"/> Dying |
| <input type="checkbox"/> Other _____ | | | |

These questions will help us get to know you better. Choose the answer that best describes what you feel or do. Your answers will be seen only by your health care provider and his/her assistant.

Health Profile

Eating/Weight/Body

14. Do you eat fruits and vegetables every day? No Yes
15. Do you drink milk and/or eat milk products every day? No Yes
16. Do you spend a lot of time thinking about ways to be skinny? Yes No
17. Do you do things to lose weight (skip meals, take pills, starve yourself, vomit, etc) Yes No
18. Do you work, play, or exercise enough to make you sweat or breathe hard at least 3 times a week? No Yes
19. Have you pierced your body (not including ears) or gotten a tattoo? Yes No

School

- 20. Is doing well in school important to you? No Yes
- 21. Is doing well in school important to your family and friends? No Yes
- 22. Are your grades this year worse than last year? Yes No Not Sure
- 23. Are you getting failing grades in any subjects this year? Yes No Not Sure
- 24. Have you been told that you have a learning problem? Yes No
- 25. Have you been suspended from school this year? Yes No

Friends and Family

- 26. Do you know at least one person who you can talk to about problems? No Yes
- 27. Do you think that your parent(s) or guardian(s) usually listen to you and take your feelings seriously? No Yes
- 28. Have your parents talked with you about things like alcohol, drugs, and sex? No Yes Not Sure
- 29. Are you worried about problems at home or in your family? Yes No Not Sure
- 30. Have you ever thought seriously about running away from home? Yes No

Weapons/Violence/Safety

- 31. Is there a gun, rifle, or other firearm where you live? Yes No Not Sure
- 32. Have you ever carried a gun, knife, club, or other weapon to protect yourself? Yes No
- 33. Have you ever been in a physical fight where you or someone else got hurt? Yes No
- 34. Have you ever been in trouble with the police? Yes No
- 35. Have you ever seen a violent act take place at home, school, or in your neighborhood? Yes No
- 36. Are you worried about violence or your safety? Yes No Not Sure
- 37. Do you usually wear a helmet and/or protective gear when you rollerblade, skateboard, or ride a bike? No Yes
- 38. Do you always wear a seat belt when you ride in a car, truck, or van? No Yes

Tobacco

- 39. Have you ever tried cigarettes or chewing tobacco? Yes No
- 40. Have any of your close friends ever tried cigarettes or chewing tobacco? Yes No
- 41. Does anyone you live with smoke cigarettes/cigars or chew tobacco? Yes No

Alcohol

- 42. Have you ever tried beer, wine, or other liquor (except for religious purposes)? Yes No
- 43. Have any of your close friends ever tried beer, wine, or other liquor (except for religious purposes)? Yes No
- 44. Have you ever been in a car when the driver has been using drugs or drinking beer, wine or other liquor? Yes No
- 45. Does anyone in your family drink so much that it worries you? Yes No Not Sure

Drugs

- 46. Have you ever taken things to get high, stay awake, calm down or go to sleep? Yes No Not Sure
- 47. Have you ever used marijuana (pot, grass, weed, reefer, or blunt)? Yes No Not Sure
- 48. Have you ever used other drugs such as cocaine, speed, LSD, mushrooms, etc.? Yes No Not Sure
- 49. Have you ever sniffed or huffed things like paint, 'white-out', glue, gasoline, etc.? Yes No Not Sure

50. Have any of your close friends ever used marijuana, other drugs, or done other things to get high? Yes No Not Sure
51. Does anyone in your family use drugs so much that it worries you? Yes No Not Sure

Development/Relationships

52. Are you dating someone or going steady? Yes No Not Sure
53. Are you thinking about having sex (“going all the way “or “doing it”)? Yes No Not Sure
54. Have you ever had sex? Yes No Not Sure
55. Have any of your friends ever had sex? Yes No Not Sure
56. Have you ever felt pressured by anyone to have sex or had sex when you did not want to? Yes No Not Sure
57. Have you ever been told by a doctor or a nurse that you had a sexually transmitted disease like herpes, gonorrhea, or chlamydia? Yes No Not Sure
58. Would you like to receive information on abstinence (“how to say no to sex”)? Yes No Not Sure
59. Would you like to know how to avoid getting pregnant, getting HIV/AIDS, or getting sexually transmitted diseases? Yes No Not Sure

Emotions

60. Have you done something fun during the past two weeks? No Yes
61. When you get angry, do you do violent things? Yes No
62. During the past few weeks, have you felt very sad or down as though you have nothing to look forward to? Yes No
63. Have you ever seriously thought about killing yourself, made a plan, or tried to kill yourself? Yes No
64. Is there something you often worry about or fear? Yes No
65. Have you ever been physically, emotionally, or sexually abused? Yes No Not Sure
66. Would you like to get counseling about something that is bothering you? Yes No Not Sure

Special Circumstances

67. In the past year have you been around someone with tuberculosis (TB)? Yes No Not Sure
68. In the past year, have you stayed overnight in a homeless shelter, jail, or detention center? Yes No
69. Have you ever lived in foster care or a group home? Yes No

Self

70. What two words best describe you?
 1) _____ 2) _____

71. What would you like to be when you grow up?

72. If you could have three wishes come true, what would they be?
 1) _____
 2) _____
 3) _____