Name:
ID:

HOW AM I DOING?
ADOLESCENTS 11 YEARS THROUGH 20 YEARS
RISK ASSESSMENT

If you have any questions or concerns about yourself, please share these with your health-care provider. We want to assist you with your needs anyway possible.

YES NO

1. Have you had contact with a person with confirmed or suspected infectious tuberculosis? (Family member or associate in jail or prison)
   [ ] [ ]

2. Have you had an x-ray or examination that may suggest tuberculosis?
   [ ] [ ]

3. Have you emigrated from a foreign country where there is a history of tuberculosis? (Asia, Middle East, Africa, Latin America)
   [ ] [ ]

4. Have you traveled to a foreign country or had contact with a native person from such a country where there is a history of tuberculosis?
   [ ] [ ]

5. Do you have HIV/AIDS?
   [ ] [ ]

6. Have you or do you live in a group home, foster care, or orphanage, or been incarcerated?
   [ ] [ ]

7. Are you physically active for a total of 30 minutes each day?
   [ ] [ ]

8. Do you have problems with activities of daily living, such as: making meals, shopping, bathing, or moving around?
   [ ] [ ]

9. Have you ever experienced feeling really down or depressed for more than a week at a time?
   [ ] [ ]

10. Have you ever had thoughts about harming yourself?
    [ ] [ ]

11. Are you concerned that someone will harm you (or your child), or worry that you will harm someone?
    [ ] [ ]

12. Has your partner or someone important to you ever physically, verbally, or sexually abused you?
    [ ] [ ]

13. Do you smoke cigarettes, use smokeless tobacco, or use other tobacco products?
    [ ] [ ]

14. Do you or have you ever used (Circle all that apply):
    - Alcohol: Beer, Wine, Liquor
    - Drugs: Prescription (nerve, sleeping, or pain medicines)
    - Street Drugs (marijuana, cocaine, crack, or others)
   [ ] [ ]

15. Have you ever felt you should cut-down on your drinking or drug use?
    [ ] [ ]

16. Do you examine your breasts (or testicles) monthly?
    [ ] [ ]

17. Do you have questions or concerns about sex or sexual orientation?
    [ ] [ ]

18. Are you planning on becoming sexually active, have you been sexually active, or are you now sexually active?
    (If NO skip to question 25.)
    [ ] [ ]

19. Since beginning sexual relations have you had more than 1 partner? If yes, total number of partners ____.  
    [ ] [ ]

20. Have you ever had a sexually transmitted infection? (Circle all that apply):
    - Gonorrhea  - Chlamydia  - Herpes
    - HIV/AIDS  - Genital Warts or HPV  - Syphilis
   [ ] [ ]

21. Do you (or your partner) use condoms to protect against sexually transmitted infections?
    [ ] [ ]

22. Do you use any kind of birth control?
    [ ] [ ]
23. Have you ever been pregnant (or gotten someone pregnant)?

24. What type of water do you drink daily? (circle all that apply: 11 years – 16 years only):
   City    Well    Cistern    Bottled Water

CIRCLE ALL THAT APPLY:
25. Are you experiencing or have you been experiencing any of the following (circle all that apply to you):

   11 Yrs. - 15 Yrs.
   - Having Dramatic Physical Changes
   - Demand and Seek Privacy
   - Preoccupied with Appearance
   - Anxious about Number of Changes in Life

   15 Yrs. - 18 Yrs.
   - Wonder About Who You Are
   - Friends Assume Great Importance
   - Sensitivity to Fads & Peers' Social Norms
   - Question Rules & Authority
   - Becoming Future Oriented in Thinking

   18 Yrs. - 20 Yrs.
   - Making Decisions about College, Work, or Military
   - Focus on Achieving Greater Autonomy
   - Seeking Mature Emotional Intimacy
   - Development of Mature Sexual Identity

26. Do you have concerns about your weight or eating habits?

27. Do you follow a special diet or are on a prescribed medication?

28. Do you eat or drink every day: (circle all that apply)
   Fried Foods    Lunch Meats    Soft Drinks    Cake    Cookies    Chips

29. Do you eat 6 servings of any of the following daily: bread, cereal, rice, or pasta?

30. Do you eat 3 servings of vegetables each day?

31. Do you eat 2 servings of fruit or drink 2 serving(s) of 100% fruit juice daily?

32. Do you eat 2 servings of any of the following daily: meat (beef, pork, chicken, turkey), fish, soup, beans, eggs or peanut butter?

33. Do you eat or drink 3 servings daily of any of the following: milk, cheese or yogurt?

QUESTIONS OR CONCERNS TO DISCUSS WITH YOUR HEALTH CARE PROVIDER:

ENTIRE FORM HAS BEEN REVIEWED AND UPDATED WITH PATIENT ON FOLLOWING DATES:
(SIGNATURE AND DATE REQUIRED)