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.
Chart# ___________________

Name__________________________________________ Today’s Date________________

   Last First Middle Initial

Birthdate ___________________    Grade in School ___________

   month     day     year

Boy or Girl (circle one)     Age ___________

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?

<table>
<thead>
<tr>
<th>Problem</th>
<th>Yes</th>
<th>No</th>
<th>Not Sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies or hay fever</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Asthma</td>
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<tr>
<td>Tuberculosis (TB)</td>
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<td></td>
<td></td>
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<tr>
<td>Seizures</td>
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<tr>
<td>Cancer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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:
    □ Height □ Neck or back □ Muscle or pain in arms/legs □ Anger or temper
    □ Weight □ Breasts □ Menstruation or periods □ Feeling tired
    □ Eyes or vision □ Heart □ Wetting the bed □ Trouble sleeping
    □ Hearing or earaches □ Coughing or wheezing □ Trouble urinating or peeing
    □ Colds/runny or stuffy nose □ Chest pain or trouble breathing □ Drip from penis or vagina
    □ Mouth or teeth or breath □ Stomach ache □ Wet dreams □ Fitting in/belonging
    □ Headaches □ Vomiting or throwing up □ Skin (rash/acne) □ Cancer
    □ 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)________________________________________________________________________________________________________