CANYON PEDIATRICS

Name: _____ Date of Birth: _____

Cell: _____ Email: _____

To be Completed by Teenage Patients (Para ser completado por pacientes adolescentes)

Do you?

Use Tobacco	☐ Yes ☐ No
Drink Beer or Alcohol	☐ Yes ☐ No
Use any kind of Drugs	☐ Yes ☐ No

Do you have concerns about any of the following?

Safety Issues?	☐ Yes ☐ No
Substance use in family?	☐ Yes ☐ No
Sexually Transmitted Diseases?	☐ Yes ☐ No
Family Planning?	☐ Yes ☐ No

How old were you when you had your first period?	Age _____
Are you sexually active?	☐ Yes ☐ No
Are you using any form of birth control?	☐ Yes ☐ No
Have you ever been pregnant?	☐ Yes ☐ No