DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-01062 (08/2019)

STATE OF WISCONSIN

HEALTHCHECK ADOLESCENT REVIEW

Screening Clinic Instructions: To be handed to adolescents 12 and over. After review, return to patient.

Patient Instructions: Sometimes it is easier to talk about things this way. If you wish, check YES or NO for each question and give this paper to the nurse. If you have any questions about this, ask the nurse to help you. This form will be returned to you.

1. Do you think something is wrong with your general health? ☐ Yes ☐ No
2. Do you feel you have to exercise more than 1 hour every day or else you feel bad about yourself? ☐ Yes ☐ No
3. Are you often upset? ☐ Yes ☐ No

4. Do you think something is wrong with your body development? ☐ Yes ☐ No
5. Do you think something is wrong with your weight and have you tried to lose or gain weight? ☐ Yes ☐ No
   If yes, how? _____
6. Is something slowing your progress in school? ☐ Yes ☐ No
7. Is something slowing your progress in work? ☐ Yes ☐ No

8. Are you having difficulties at home? ☐ Yes ☐ No
9. Do you have difficulty making friends when you are out? ☐ Yes ☐ No
10. Do you think something is wrong with your sexual feelings? ☐ Yes ☐ No

11. Do you think something is wrong with your heart? ☐ Yes ☐ No
12. Do you think something is wrong with your skin? ☐ Yes ☐ No
13. Do you think something is wrong with your eyes? ☐ Yes ☐ No

14. Do you cough much or have trouble breathing? ☐ Yes ☐ No
15. Are you concerned about your stomach or bowels ☐ Yes ☐ No
16. Do you think you have cancer? ☐ Yes ☐ No
    If yes, where? _____

17. Does it burn when you go to the bathroom? ☐ Yes ☐ No
18. Do you have pain in your muscles or when you move? ☐ Yes ☐ No
19. Do you have questions about drinking alcohol or using other drugs? ☐ Yes ☐ No

20. Do you have questions about pregnancy or birth control? ☐ Yes ☐ No
21. Do you have questions about discharge from your sex organs or sexually transmitted diseases? ☐ Yes ☐ No
22. Do you have questions about masturbation or touching yourself? ☐ Yes ☐ No

23. If you wish, check each box that you have questions or concerns about. The clinic will be able to give you places and / or names to contact for further questions.

☐ Dating ☐ School Problems ☐ Birth Control ☐ Pregnancy
☐ Drugs ☐ Abortion ☐ Sexually Transmitted Diseases ☐ Weight Control

MALES ONLY

24. Do you have concerns about “wet dreams” ☐ Yes ☐ No
25. Do you have concerns about the size of your sex organ? ☐ Yes ☐ No

FEMALES ONLY

26. Have you started your periods? ☐ Yes ☐ No
    If yes, when? _____
    If no, then you may skip the remainder of these questions.
27. How often do you get your period? _____
28. Do you have problems with your periods? ☐ Yes ☐ No
29. Do you take any medicine for your periods? ☐ Yes ☐ No
30. Have you ever had problems with a discharge, bleeding or anything else between your periods? ☐ Yes ☐ No
31. Please answer the following if you think you are pregnant?
    Do you live in a house built before 1980 where there is paint peeling? ☐ Yes ☐ No
    Do you have a hobby that includes lead bullets, lead weights for fishing or lead glass? ☐ Yes ☐ No
    Do you eat non-food items such as clay, dirt, azarcon, Pay-loo-ah or Greta? ☐ Yes ☐ No

ANY OTHER COMMENTS OR QUESTIONS?