Adolescent Risk Screening Questions

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Name: _____
Date of Birth: _____
Date: _____

VISION

1. Is the blackboard difficult to see?	□ Yes	□ No
2. Do you hold books close to your face when you read?	□ Yes	□ No
3. Do others say you squint?	□ Yes	□ No
4. Have you ever failed a school vision test?	□ Yes	□ No
5. Can you recognize faces at a distance?	□ Yes	□ No

HEARING

1. Do you have any problems hearing over the phone?	□ Yes	□ No
2. Is it difficult to follow the conversation when two or more people are talking?	□ Yes	□ No
3. Do people complain you turn the volume of the TV too high?	□ Yes	□ No
4. Do you have to strain to understand conversations?	□ Yes	□ No
5. Do you have trouble hearing with a noisy background?	□ Yes	□ No
6. Do you have to ask people to repeat themselves?	□ Yes	□ No
7. Do many people seem to mumble or not speak clearly?	□ Yes	□ No
8. Do people get annoyed because you misunderstand what they say?	□ Yes	□ No

ANEMIA

1. Does your diet include iron-rich foods such as meat, eggs iron-fortified cereals or beans?	□ Yes	□ No
2. Are you a vegetarian?	□ Yes	□ No
3. Have you ever been diagnosed with iron deficiency anemia?	□ Yes	□ No
For females:		
4. Do you have excessive menstrual bleeding or other blood loss?	□ Yes	□ No
5. Does your period last more than five days?	□ Yes	□ No

DYSLIPIDEMIA

1. Do you smoke cigarettes?	□ Yes	□ No
2. Have your parents or grandparents, before fifty-five years of age had:		
A heart attack (MI)?	□ Yes	□ No
Chest pain (angina)?	□ Yes	□ No
Peripheral vascular disease?	□ Yes	□ No
Coronary atherosclerosis?	□ Yes	□ No
Sudden cardiac death?	□ Yes	□ No
3. Do you consume excessive amounts of saturated fats and cholesterol?	□ Yes	□ No

SUBSTANCE USE

1. Have you ever had an alcoholic drink?	□ Yes	□ No
2. Have you ever used marijuana?	□ Yes	□ No
3. Have you ever used any other drug to get high?	□ Yes	□ No

SEXUAL ACTIVITY

1. Are you sexually active?	□ Yes	□ No