

Long-Term Follow-Up Study

UNIVERSITY OF MINNESOTA

Teen Health Survey

This survey is about health habits. It has been developed so you can tell us what you do that may affect your health. The information you and other young people your age give will be used to develop better health education programs for people like yourself.

The answers you give will be kept private. Your teachers, parents, doctors, brothers, sisters, or friends will not see your answer, only the University researchers will see this information. Answer the questions based on what you really do.

Place all your answers on the answer sheet. Please try not to skip any questions. However, it is okay to not answer a question if it makes you feel uncomfortable.

The whole survey usually takes about 40 minutes to complete. You do not have to do it all in one sitting. Take as much time as you need to answer the questions.

Thank you for your help.

INSTRUCTIONS

1. Do NOT put your name anywhere on the survey.
2. Make an X in the square for your answer.
3. Make no stray marks of any kind. Other than your responses, please keep the form as clean as possible. Erase cleanly any answer you wish to change.
4. Sign the Teen Assent Form



5. Put the survey in the large envelope and mail it back. Put the assent form in the small envelope and mail it back.

CHIP-AE

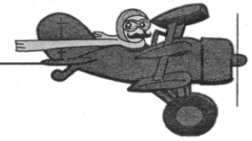
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How to fill out this survey

Please read this page!



Thank you for agreeing to complete our health survey. Please read these instructions carefully before answering the questions in the survey. Wherever you see this symbol, , it means that important instructions follow which you must read before answering the next question(s). If you see this symbol, , it means that if you checked that box, you should answer the question that follows. Given below are some examples of the different ways you will answer the questions.

 For some questions, you will **PUT AN X IN THE BOX** that goes with your answer, like this:

EXAMPLE 1:

In the **PAST 4 WEEKS**, on how many days

	No days	1 to 3 days	4 to 6 days	7 to 14 days	15 to 28 days
1. did you feel really sick?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

EXAMPLE 2:

2. Is English the language you speak at home most of the time?

No

Yes

For some questions, you will **WRITE A NUMBER ON THE ANSWER LINE**, like this:

EXAMPLE 3:

3. How many days did you exercise in the **PAST MONTH**?

Number of days 9

Or **WRITE A NUMBER IN A BOX**, like this:

EXAMPLE 4:

4. How old are you?

1	7
---	---

Go to next page and begin

SECTION A

Section A

For each statement below, write in the answer or make an X in the box that applies.

1. What is today's date?

Month

Day

Year

2. How old are you? Age:

3. What is the month, day, and year you were born?

Month

Day

Year

4. What is your sex?

Male

Female



5. Which of these best describes you?


White, not Hispanic

American Indian or Alaskan

Black/African American, not Hispanic

Asian or Pacific Islander

Hispanic/Latino

Other  Please describe:

6. Is English the language you speak at home most of the time?

No

Yes

7. Circle the number of the school grade you are in now:

5

6

7

8


9

10

11

12

Not in school

 If you are not in school, what was the highest grade you completed? _____

8. How many people are living in your home?  Please count yourself: _____

Section A

9. Who are all the people living in your home?

☞ Check the box next to each person who lives in your home



- | | |
|--------------------------------------|--|
| <input type="checkbox"/> Mother | <input type="checkbox"/> Stepfather |
| <input type="checkbox"/> Father | <input type="checkbox"/> Foster parents |
| <input type="checkbox"/> Grandmother | <input type="checkbox"/> Brothers |
| <input type="checkbox"/> Grandfather | <input type="checkbox"/> Sisters |
| <input type="checkbox"/> Stepmother | <input type="checkbox"/> Other relatives |
| | <input type="checkbox"/> Other people not related to you |

10. What is the **highest** grade in school that your mother (or female guardian) finished?

- She did not finish high school
- She got a high school diploma or GED
- She had some college
- She finished college
- She finished graduate school, law school, or medical school
- Don't know

11. Is your mother (or female guardian) now . . .

☞ Check all boxes that apply.



- Working full-time
- Working part-time
- Not working and looking for work
- Disabled and not working
- Not working and not looking for work
- Retired
- Full-time student
- Part-time student
- Don't know

12. What is the highest grade in school that your father (or male guardian) finished?

- He did not finish high school
- He got a high school diploma or GED
- He had some college
- He finished college
- He finished graduate school, law school, or medical school
- Don't know



13. Is your father (or male guardian) now . . .

Check all boxes that apply.

- Working full-time
- Working part-time
- Not working and looking for work
- Disabled and not working
- Not working and not looking for work
- Retired
- Full-time student
- Part-time student
- Don't know

14. Does your family get a welfare check?

- No
- Yes
- Don't know

15. Does your family get food stamps?

- No
- Yes
- Don't know




16. Do you or any of your brothers or sisters get free or reduced cost school lunches?

- No
- Yes
- Don't know

SECTION B

Section B

 For statements 1 to 11, mark the box below the line to show if you completely agree, mostly agree, agree a little, or do not agree with the statement.

	Completely Agree	Mostly Agree	Agree a Little	Do Not Agree
1. I am full of energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I resist illness very well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. When I get sick, I usually recover quickly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I am well coordinated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I have a lot of good qualities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I am very physically fit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I have much to be proud about	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. I like being the way I am	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I am satisfied with how I live my life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. My muscle strength is really good	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. I feel socially accepted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>


12. How is your health in general?

- Excellent
- Very good
- Good
- Fair
- Poor



SECTION C

Section C

 These questions are about how you have been feeling over the **PAST 4 WEEKS**. Please mark the box to indicate your answer to each question.

In the PAST 4 WEEKS, on how many days . . .

	No days	1 to 3 days	4 to 6 days	7 to 14 days	15 to 28 days
1. Did you feel really sick?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Did you wake up feeling tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Did you tire easily or feel like you had no energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Did you have watery or itchy eyes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Did you have skin problems, such as itching or pimples?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Did you have a cough?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Did you have fever or chills?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Were you dizzy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Did you have wheezing or trouble breathing (when you weren't exercising)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Did you have chest pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Did you have a headache?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Did you have aches, pains, or soreness in your muscles or joints?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Did you have a stomach ache?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Did you have pain that really bothered you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section C

In the PAST 4 WEEKS, on how many days . . .

	No days	1 to 3 days	4 to 6 days	7 to 14 days	15 to 28 days
15. Did you vomit or feel like vomiting?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Did you have an unusual discharge from your sex organs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Did you have trouble passing your urine (peeing) or have burning when you urinated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Did you have trouble eating or have a poor appetite?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Did you have trouble falling asleep or staying asleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Did you have diarrhea or loose bowel movements?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Did you have constipation or hard bowel movements?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Did you feel depressed or blue?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Did you have trouble relaxing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Were you nervous or uptight?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Were you moody?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Were you irritable or grouchy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. Did you cry a lot?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. Were you afraid of things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. FOR GIRLS ONLY: Did you have menstrual problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Thinking about your *good* feelings,
In the PAST 4 WEEKS, on how many days . . .

	No days	1 to 3 days	4 to 6 days	7 to 14 days	15 to 28 days
30. Were you free of pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. Did you wake up feeling refreshed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. Did you feel really healthy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. Did you feel like you were doing everything just right?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. Did you feel loved and wanted?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

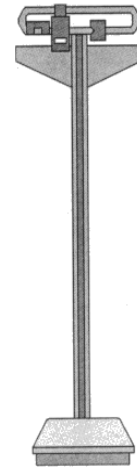
In the PAST 4 WEEKS, on how many days did a *health or emotional problem* cause you to . . .

	No days	1 to 3 days	4 to 6 days	7 to 14 days	15 to 28 days
35. Miss more than a half day of school or work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36. Stay in bed more than half a day, but not miss school or work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37. Cut down on other things you usually do, but not miss school or stay in bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38. Have trouble walking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
39. Have trouble running?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40. Have trouble bending, lifting, stooping or reaching?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
41. Have trouble using your hands or fingers, like writing with a pencil, tying your shoelaces, or buttoning clothing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section C

42. In the PAST 4 WEEKS, have you lost weight without trying?

- No
- Yes, 1 to 4 pounds
- Yes, 5 to 9 pounds
- Yes, 10 to 14 pounds
- Yes, more than 15 pounds



In the PAST 12 MONTHS,
how many times did you do the following?

	None	Once or twice	Several times
43. Vomit on purpose to lose weight?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
44. Go on an eating binge (you could not stop eating)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

45. Have you **ever** tried to seriously hurt yourself or kill yourself?

- No, never
- Yes, more than a year ago
- Yes, in the past year
- Yes, in the past 4 weeks
- Yes, in the past 7 days

SECTION D

Section D

1. In the **PAST 4 WEEKS**, on how many days did you exercise or play sports hard enough to make you breathe hard, make your heart beat fast, or make you sweat for 20 minutes or more?

- No days
- 1 to 9 days
- 10 to 13 days
- 14 to 20 days
- 21 or more days

2. In the **PAST 4 WEEKS**, how many situps did you do?

- No sit-ups
- 1-10 sit-ups
- 11-20 sit-ups
- 21-50 sit-ups
- 51 or more sit-ups

3. In the **PAST 4 WEEKS**, how far did you walk at any one time without resting and without getting tired?

- I didn't walk at all
- Less than a quarter of a mile (less than 2 blocks)
- A quarter mile to one half mile (3 to 6 blocks)
- One half mile to one mile (6 to 12 blocks)
- More than one mile (more than 12 blocks)



4. In the **PAST 4 WEEKS**, what is the longest time you ran without stopping?




- I didn't run
- 1 to 10 minutes
- 11 to 19 minutes
- 20 to 29 minutes
- 30 minutes or more

5. In the **PAST 12 MONTHS**, how often did you play on a team that has a coach, other than in gym class?

- Never
- Once or twice
- Several times

SECTION E

 The questions on the next few pages are about different things you might do.

**In the PAST 12 MONTHS,
how many times did you do the following?**



	None	Once or twice	Several times
1. Race on a bike, skateboard or in a boat or car for excitement?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do something risky or dangerous on a dare?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Break a rule that your parents set just for the thrill of seeing whether you could get away with it?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Steal or shoplift?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Slip out at night when your parents thought you were asleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Willingly ride in a car with someone you knew would drive dangerously?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. In the **PAST 4 WEEKS**, about how many hours did you usually watch TV or videos on an average school day?

- None
- Less than 1 hour
- 1 to 2 hours
- 3 to 4 hours
- 4 or more hours

When was the last time you did this?

	Never	More than a year ago	In the past year	In the past month	In the past week
8. Rode a bicycle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Wore a helmet when riding a bicycle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Rode a motorbike (motorcycle, minibike or ATV - all terrain vehicle?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Wore a helmet when riding a motorbike?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

When was the last time you did this?

	Never	More than a year ago	In the past year	In the past month	In the past week
12. Drove a car?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Drank alcohol or used drugs before driving a car or riding a motorbike?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Wore a seat belt in a car or truck?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Carried a weapon, such as a gun, razor, or big knife, for protection?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Belonged to a gang?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Smoked cigarettes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Chewed or dipped tobacco, used snuff?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Drank beer, wine or wine coolers?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Drank hard liquor or mixed drinks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Had 5 or more drinks in a row (like in one night or at a party)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Used marijuana?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Took steroids to help build your muscles?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Used inhalants such as airplane glue or white out?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Used any kind of cocaine, ice or crack?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Used or injected (shot up) any other type of illegal drug, such as LSD, PCP, mushrooms, speed, downers or heroin?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. Ran away from home?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. Threatened to hurt someone?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. Physically attacked someone?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. Stole something worth more than \$10?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. Destroyed something belonging to someone else?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section E

How many of your friends do the following:

<i>☞ Check only one box</i>	None	Some	Most	All
32. Smoke cigarettes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. Drink alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. Smoke marijuana	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. Use other drugs (cocaine, stimulants, pills)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36. Have sexual intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

37. Have you ever had sexual intercourse (made love or gone all the way)?

- No *☞ Go to question 38*
- Yes *☞ Answer questions A to E*
- Don't know *☞ Go to question 38*

A. How old were you when you had sexual intercourse for the first time?

- Younger than age 13 Age 15
- Age 13 Age 16 or older
- Age 14

B. How many people of the **opposite sex** have you had sex with?

- No opposite-sex partner Three opposite-sex partners
- One opposite-sex partner Four or more opposite-sex partners
- Two opposite-sex partners

C. How many people of the **same sex** have you had sex with?

- No same-sex partner Three same-sex partners
- One same-sex partner Four or more same-sex partners
- Two same-sex partners

D. Which of the following did you or your partner use to prevent pregnancy or sexually transmitted diseases (STDs) or VD the **last time** you had sexual intercourse?

☞ Check all boxes that apply

- Nothing
- Rubber or condom
- Birth control pill, Norplant, or Depo Provera
- Withdrawal or pulling out
- Foam, cream, jelly, or suppository
- Something else
- Diaphragm or sponge

E. Have you ever been pregnant (**GIRLS**) or gotten someone pregnant (**BOYS**)?

- No
- Yes
- Don't know

	No	Yes	Don't know
38. Is there a working smoke detector or smoke alarm in your home?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
39. Does anyone in your household smoke cigarettes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>☞ Don't count yourself if you smoke</i>			
40. Is there a working fire extinguisher in your home?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
41. Are there any guns in your home?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>


42. In general, is there a certain time of night when you have to be home on **SCHOOL NIGHTS**?

☞ If you are not in school now, think about the last month you were in school



- Not usually permitted to go out on school nights
- Have to be in by 8:00 pm
- Have to be in by 9:00 pm
- Have to be in by 10:00 pm
- No particular time

Section E

 The next questions are about how you would deal with a common problem

IMAGINE: *You have had a big fight with a close friend and you think that he or she did not understand you and would not listen to what you were saying.*



For each statement below, decide how likely you would be to act that way . . .


	Very unlikely	Somewhat unlikely	Somewhat likely	Very likely
43. I would talk to others to get advice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
44. I would try to see the good that could come out of the situation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
45. I would figure out who was to blame for the situation, and blame them (or myself)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
46. I would try to solve the problem directly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
47. I would talk about how I was feeling to a friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
48. I would try to calm myself down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
49. I would keep thinking and wishing this thing had never happened	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
50. I would turn to my family or other adult to help me feel better	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51. I would do something else	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

In the PAST 4 WEEKS, how often did you eat the following types of foods. . .

	Rarely or never	A few days a month	Several days a month	About every day	More than once a day
52. Fruits or vegetables?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
53. Meat, chicken or fish that was not fried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
54. 2 % or skim milk, or yogurt?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
55. Grains and cereals like whole-wheat bread, bran cereals, or beans?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
56. Fast foods, such as fried chicken, french fries, onion rings, and hamburgers?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
57. Salty foods, such as salted pretzels, chips, or pickles?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
58. Sweets such as regular soda, doughnuts, candy bars?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION F



 This section is about health problems that you had in the **PAST 12 MONTHS**

In the PAST 12 MONTHS, how many times did you have . . .

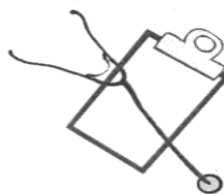
	None	Once	2 times	3 times	4 or more times
1. A cold or flu?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Sinus trouble or sinusitis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. A sore throat or tonsillitis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. An ear infection?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Upset stomach with vomiting or diarrhea or fever?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Bronchitis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. A skin infection?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Pneumonia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. A bladder infection or urinary tract infection?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Any fungal diseases like athlete's foot or ringworm?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Infectious mononucleosis (mono)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you NOW have . . .

	No	Yes
12. A speech problem such as a lisp, stammering, or stuttering?	<input type="checkbox"/>	<input type="checkbox"/>
13. A part of your body that is disabled or deformed?	<input type="checkbox"/>	<input type="checkbox"/>
14. A vision problem?	<input type="checkbox"/>	<input type="checkbox"/>
15. A hearing problem?	<input type="checkbox"/>	<input type="checkbox"/>


Has a doctor ever said you had . . .

	No Never	Yes, but NO PROBLEMS with it in last 12 months	Yes, and HAD PROBLEMS with it in last 12 months
16. Serious acne, eczema or other allergic rashes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Gum disease (not tooth cavities)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Asthma?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Sugar diabetes (sugar in the blood)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Sickle cell anemia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Anemia, tired or thin blood?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Rheumatic fever?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Heart disease or a heart condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Migraine headaches?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Epilepsy (seizures)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. Arthritis or any joint disease or joint problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. Curvature of the spine or scoliosis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. Any other condition affecting the bone, cartilage, muscle, or tendon?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. An emotional/mental problem or behavior problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. A learning disability or attention disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Section F

Has a doctor ever said you had . . .

	No Never	Yes, but NO PROBLEMS with it in last 12 months	Yes, and HAD PROBLEMS with it in last 12 months
32. An eating disorder like anorexia or bulimia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. Lead poisoning?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. Hay fever or allergies?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. A sexually transmitted disease (STD) or venereal disease (VD) like gonorrhea (clap), syphilis, chlamydia, genital warts, or genital herpes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36. Any other serious disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
 <i>If yes, please describe:</i> _____			
37. FOR GIRLS ONLY: Pelvic inflammatory disease (PID)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

38. About how many tooth cavities have you ever had?


- None
- 1 or 2 cavities
- 3 or 4 cavities
- 5 or more cavities
- Don't know



In the PAST 12 MONTHS, did you have any of the following injuries . . .

	No	Yes, but I DID NOT see a doctor or a nurse	Yes, and I DID see a doctor or a nurse
39. A bad cut or scrape?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40. A bad sprain or torn ligament?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
41. A broken bone, dislocated joint, or broken nose?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
42. A bad head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
43. A gun shot wound or stab wound?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
44. A bite from another person or animal?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
45. A bad burn?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

46. During the PAST 12 MONTHS, how many times did anyone physically hurt you on purpose?

- None  Go to section G
- 1 time
- 2 times
- 3 times
- 4 or more times

A. Did being hurt by someone . . .	No	Yes
(1) Cause a change in your feelings (like fear or depression)?	<input type="checkbox"/>	<input type="checkbox"/>
(2) Cause a change in what you do (like where you go and how you act)?	<input type="checkbox"/>	<input type="checkbox"/>
(3) Cause a physical injury?	<input type="checkbox"/>	<input type="checkbox"/>
(4) Cause you to get medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>

B. Did you know any of the people who hurt you?

- No
- Yes



SECTION G

Section G

Thinking about your family, about how many days in the PAST 4 WEEKS did your parents or other adults in your family . . .

	No days	1 to 3 days	4 to 6 days	7 to 14 days	15 to 28 days
1. Spend time with you doing something fun?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Talk with you or listen to your opinions and ideas?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Eat meals with you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

In the PAST 4 WEEKS, on how many days . . .



	No days	1 to 3 days	4 to 6 days	7 to 14 days	15 to 28 days
4. Have you liked being a member of your family?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Did you and your family get along?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Did you lie or cheat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Did you argue a lot?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Did you hang around with others who get into trouble?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

In the LAST 4 WEEKS that you were in school, on how many days did you . . .

	No days	1 to 3 days	4 to 6 days	7 to 14 days	15 to 28 days
9. Disobey at school?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Have trouble getting along with your teachers?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Have trouble concentrating or paying attention in school?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Have trouble getting your school work done?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section G

13. Which of the following statements best describes how you did in school in the **PAST 4 WEEKS?**

If you are not in school now, think about the last month you were in school

- Excellent student Average student
 Good student Below average student



14. Which of the following statements best describes how you did your homework in the **PAST 4 WEEKS?**

If you are not in school now, think about the last month you were in school

- Did very well, could not do better
 Did about as well as I could
 Could have done a little better
 Could have done much better

Have you done any of the following things in the PAST 2 SCHOOL YEARS?

(including this school year)

If you are not in school now, think about the last 2 years you were in school

	No	Yes
15. I dropped out of school.	<input type="checkbox"/>	<input type="checkbox"/>
16. I was on the honor roll.	<input type="checkbox"/>	<input type="checkbox"/>
17. I received a school award or prize.	<input type="checkbox"/>	<input type="checkbox"/>
18. I failed a subject.	<input type="checkbox"/>	<input type="checkbox"/>
19. I failed a grade (had to repeat a year).	<input type="checkbox"/>	<input type="checkbox"/>
20. I was suspended or expelled.	<input type="checkbox"/>	<input type="checkbox"/>
21. I was an officer in a school club or organization.	<input type="checkbox"/>	<input type="checkbox"/>

The following questions are about work, things like a part-time job, babysitting, a paper route, or mowing lawns.

22. In the **PAST 4 WEEKS**, did you earn any money **other than** from work you do at home?

- No *Go to Question 27*
 Yes

A. About how many days do you work for pay **each week**?

- 1 day 4 days
 2 days 5 or more days
 3 days

B. About how many hours do you usually work for pay **each week**?

- 1 to 5 hours 16 to 20 hours
 6 to 10 hours 21 or more hours
 11 to 15 hours

In the PAST 4 WEEKS, how often did you do the following . . .

	Never	Once or twice	Several times
23. I was late for work.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. I was absent from work.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. I failed to do the things I was supposed to do.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. I had trouble getting my work done.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you feel that . . .

	No	Yes
27. There is an adult you could turn to for help if you have a real problem?	<input type="checkbox"/>	<input type="checkbox"/>
28. There are any adults who are really interested in what you do and encourage you to do your best?	<input type="checkbox"/>	<input type="checkbox"/>
29. You are safe in school?	<input type="checkbox"/>	<input type="checkbox"/>
30. You are safe in your neighborhood?	<input type="checkbox"/>	<input type="checkbox"/>
31. Overall, you are challenged to do your best?	<input type="checkbox"/>	<input type="checkbox"/>

Please turn the page

Thank you for filling out the Teen Health Survey!

In appreciation of your efforts we will make a contribution on your behalf to a charitable organization of your choice. Please choose an organization from the list below, or write in another organization to which you would like us to make a contribution.

Make-A-Wish Foundation

Grants the wishes of children with life-threatening illnesses.

Camp Ronald McDonald for Good Times

Offers regular camp activities adapted to the needs of campers. For anyone under 18 who has had cancer or a similar illness. Also offers a camp for siblings.

Paul Newman Hole in the Wall Gang Camp


Residential summer camp in Connecticut where children with cancer or other serious blood diseases can find camaraderie and "be a kid."

Barretstown Gang Camp

An international summer program for seriously ill children set in Ireland's Wicklow Mountains.

Lance Armstrong Foundation

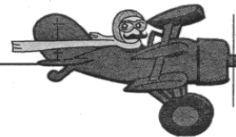
Helps people manage and survive cancer by providing information, services, and support.

Other  Please describe:

**After completing this questionnaire, please return by using
the enclosed envelope, and mail to:**

**Long-Term Follow-Up Study
Department of Pediatrics
University of Minnesota
420 Delaware St. SE, Mayo Mail Code 715
Minneapolis, MN 55455**

THANK YOU!!



We hope you have enjoyed filling out the survey.