



EARLY SEXUAL DEVELOPMENT QUESTIONNAIRE

(IF YOU CANNOT ANSWER A QUESTION, PLEASE LEAVE IT BLANK. PLEASE PRINT)

NAME: _____ DATE: _____

DATE OF BIRTH: _____ CURRENT AGE: _____ YEARS _____ MONTHS
MONTH DAY YEAR

A. APPROXIMATE AGE OF:

- 1. BREAST DEVELOPMENT _____ NONE
- 2. PUBIC HAIR _____ NONE
- 3. "ARM PIT" HAIR _____ NONE
- 4. ACNE _____ NONE
- 5. BODY ODOR _____ NONE
- 6. GREASY SKIN _____ NONE
- 7. BEHAVIORAL CHANGES _____ NONE
- 8. MENSES _____ NONE

B. HAS THERE BEEN A HISTORY OF:

- 1. HEAD TRAUMA YES NO
- 2. LOSS OF CONSCIOUSNESS YES NO
- 3. SEIZURE YES NO
- 4. MOTOR VEHICLE ACCIDENT YES NO
- 5. SURGERY OF THE HEAD OR FACE YES NO
- 6. MENINGITIS YES NO
- 7. RADIATION TO THE HEAD/SPINE YES NO

IF YES, PLEASE DESCRIBE: _____

C. DOES YOUR CHILD HAVE ANY OF THE FOLLOWING:

- 1. SEVERE OR CHRONIC HEADACHES YES NO
- 2. FREQUENT URINATION & DRINKING BEHAVIOR YES NO
- 3. UNEXPLAINED VOMITING YES NO
- 4. RECENT GROWTH SPURT YES NO
- 5. AREAS ON SKIN OF INCREASED/DECREASED PIGMENT MARKINGS YES NO

IF YES PLEASE DESCRIBE: _____

D. CURRENT MEDICATIONS:

E. FAMILY HISTORY: (IF YES, PLEASE LIST RELATIONSHIP)

RELATIONSHIP

- 1. DIABETES _____
- 2. THYROID PROBLEM _____
- 3. EARLY PUBERTY _____
- 4. NEUROFIBROMATOSIS _____

FAMILY MEMBER	AGE	APROX. HEIGHT	AGE OF PUBERTY
FATHER	_____	_____	_____
MOTHER	_____	_____	_____
SIBLING	_____	_____	_____
SIBLING	_____	_____	_____
SIBLING	_____	_____	_____