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ADOLESCENT HEALTH HISTORY

(Use for ages 8 to 16)

Today's Date: _____

Patient Name: _____ Date of Birth: _____ Age: _____

Pharmacy (Name and location): _____

PAST MEDICAL HISTORY

Previous Doctor: _____

Allergies/reactions to medicines or vaccines: _____

Current Medications: (including vitamins, herbs, supplements, birth control pills)

Name	Dose	How many times per day	When started

Major Medical Problems: None Yes (list) _____

Hospitalizations/Operations: None Yes (list) _____

Broken bones/Severe Injuries: None Yes (list) _____

REVIEW OF SYSTEMS

Please check (✓) any current problems your child has on the list below:

General
☐ fever/chills/excessive sweating
☐ unexplained weight loss/gain

Eyes
☐ squinting/cross eyed

Ears/Nose/Throat
☐ usually loud voice/hard of hearing problems
☐ mouth breathing/snoring
☐ bad breath
☐ frequent runny nose with sleep
☐ problems with teeth/gums

Lungs/Respiratory
☐ cough/wheeze
☐ chest pain

Gastrointestinal
☐ nausea/vomiting/diarrhea
☐ constipation
☐ blood in bowel movement

Genitourinary
☐ bedwetting
☐ pain with urination
☐ discharge: penis or vagina

Allergy
☐ hay fever/itchy eyes

Neurological
☐ headaches
☐ weakness
☐ clumsiness
☐ speech

Psychiatric/Emotional
☐ anxiety/stress
☐ problems with sleep
☐ depression

Heart/Cardiovascular
☐ nail biting/thumb sucking
☐ tires easily with exercise
☐ bad temper/jealousy
☐ shortness of breath
Skin
Blood/Lymph
☐ fainting
☐ rashes
☐ unexplained lumps
☐ chest pain with exercise
☐ unusual moles
☐ easy bruising/bleeding

Musculoskeletal
☐ muscle/joint pain

SOCIAL/SCHOOL HISTORY Current grade: _____ Name of School _____

Concerns about school performance? ☐ No ☐ Yes _____

Concerns about relationship with teachers? ☐ No ☐ Yes _____ Students? ☐ No ☐ Yes _____

School grades: _____ Best friend? ☐ No ☐ YesMany friends? ☐ No ☐ Yes
Dating? ☐ No ☐ Yes

Sexually active? ☐ No ☐ Yes Using birth control? ☐ No ☐ Yes Would like more information? ☐ No ☐ Yes

Females: Have you started your period? ☐ No ☐ Yes Last Menstrual Period: _____

Involved in activities/sports/exercise? ☐ No ☐ Yes (list) _____

ADOLESCENT HEALTH HISTORY

Patient's Name: _____ Today's Date: _____

FAMILY HISTORY Please indicate family members (mother, father, sister, brother, aunt, uncle, grand parent)

Alcoholism _____ Heart Attack _____ High Cholesterol _____ Stroke _____

Cancer _____ High Blood Pressure _____ Depression/Suicide _____
Diabetes_____

In the past year, have there been any changes in your family? (check all that apply)

☐ Marriage ☐ Separation ☐ Divorce ☐ Move to new neighborhood ☐ Change to new school

☐ Serious illness ☐ Loss of job ☐ Death ☐ Birth ☐ Other changes _____

Who lives at home with you?

Name	Age	Relationship

IMMUNIZATIONS/INFECTIOUS DISEASE Did you bring your child's immunization record with you today?

☐ Yes ☐ No ☐ Will bring to next appointment ☐ Records with another care provider (name) _____

Has your child had: ☐ Chicken Pox ☐ Measles ☐ Mumps ☐ Rubella ☐ Tuberculosis (TB)

☐ Hepatitis B ☐ Meningitis ☐ Pneumonia ☐ Influenza (flu) ☐ Other Disease _____

PREVENTION/SAFETY

What is your dentist's name? _____ Date of last dental exam: _____

Do you or does anyone in your home:

Use tobacco products? ☐ No ☐ Me ☐ Household member Type: _____ Amount: _____

Drink alcohol? ☐ No ☐ Me ☐ Household member Type: _____ Amount: _____

Use illegal drugs? ☐ No ☐ Me ☐ Household member Type: _____ Amount: _____

Does your home have smoke detectors? ☐ No ☐ Yes

Do you have a gun in your house? ☐ No ☐ Yes if yes, is it unloaded and out of reach? ☐ No ☐ Yes

Do you regularly use:

Helmets for bikes/boards/ATVs/motorcycles? ☐ No ☐ Yes

Seat belts when riding or driving a car? ☐ No ☐ Yes

OTHER CONCERNS Please review this list and check any concerns you have about the patient:

☐ Physical development ☐ Emotional development ☐ Sleep patterns

☐ Weight ☐ Diet/Nutrition ☐ Amount of physical activity

☐ Relationship with parents and family ☐ Choice of friends ☐ Self image/self worth

☐ Excessive moodiness or rebellion ☐ Depression ☐ Lying, stealing, vandalism

☐ Violence/gangs/guns/weapons ☐ School grades/absences ☐ Drug use

☐ Smoking/chewing tobacco ☐ Alcohol use ☐ Sexual behavior

☐ Sexual orientation (heterosexual, gay) ☐ Pregnancy risk ☐ Sexually transmitted disease

What is your greatest challenge for you/your child?

_____

What about you/your adolescent makes you proud?

_____

Is there anything you would like to discuss in private today?

_____

Signature of person completing this form:

_____

Relationship to patient: _____