



Adolescent Medical History Form

PLEASE COMPLETE ALL 4 PAGES

Please answer the following questions. This form will NOT be put directly into your medical chart. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details. Your answers are kept confidential and are NOT shared without your consent. **Thank you!**

AGE: _____ **How would you rate your general health?** Excellent Good Fair Poor

WHAT CONCERNS DO YOU HAVE ABOUT YOUR HEALTH OR BODY? _____

PLEASE LIST ALL MEDICATIONS, VITAMINS, HERBS AND SUPPLEMENTS YOU TAKE:

Name	Dose (for example, mg/pill)	How many times per day	When started
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES/REACTIONS TO MEDICINES or VACCINATIONS: _____

PREVENTIVE CARE: When were your most recent:

Hepatitis A shot _____	Hepatitis B shot _____	Influenza (flu shot) _____	Measles shot _____
Pneumovax shot _____	Rubella shot _____	Tetanus (Td) shot _____	
Varicella (chicken pox) shot or illness _____	PPD (Tuberculosis skin test) _____	Dental Exam _____	

PERSONAL MEDICAL HISTORY: Please list any major medical problems and their dates.

Hospitalizations/operations (with dates): _____

Broken bones or severe injuries (with dates): _____

SOCIAL HISTORY: Who lives at home with you?

Name	Age	Relationship to you	Occupation	Highest Education Level
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Are your parents Married Unmarried Separated Divorced **If divorced or separated, when?** _____

Do you have any pets at home? _____ **If so, what kind and how many?** _____

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

- | | | |
|-------------------------------------|---|---|
| <input type="checkbox"/> Marriage | <input type="checkbox"/> Loss of job | <input type="checkbox"/> Birth |
| <input type="checkbox"/> Separation | <input type="checkbox"/> Move to new neighborhood | <input type="checkbox"/> Serious illness |
| <input type="checkbox"/> Divorce | <input type="checkbox"/> Change to new school | <input type="checkbox"/> Death |
| | | <input type="checkbox"/> Other changes/stresses |

SCHOOL HISTORY: Current grade _____ Name of school _____

Do you have any concerns about your performance in school? _____ Do your parents? _____ Do your teachers? _____

What do you want to do or be after you complete school? _____

EXERCISE: What sports or exercise do you do? _____ Days per wk? _____ Minutes each time? _____

How many minutes per day do you watch TV or use a computer? _____

INJURY PREVENTION:

Do you wear sunscreen when in the sun? Yes No

Are you frequently exposed to loud noises, such as concerts, earphones or machinery? Yes No

Do you wear a seatbelt when riding in a car, truck or van? Yes No

Do you wear a helmet when skateboarding, rollerblading, or riding a bicycle or scooter? Yes No

Do you ride a motorcycle, hang glide or fly an airplane? Yes No

Does your home have smoke detectors? Yes No

Is there a gun in your home? Yes No

If so, is it kept unloaded and locked out of reach? Yes No

Do students in your school carry guns or knives to school? Yes No

Are you worried about violence or your safety? Yes No

Have you ever been in trouble with the police? Yes No

DIET: Do you eat 5 servings of fruits and vegetables every day? Yes No

Do you drink 4 glasses of milk (1 quart) daily or get calcium from other sources? Yes No

Are you happy with your current weight? Yes No

Do you follow a special diet? Yes No If so, please describe: _____

Have you ever done any of the following to lose weight:

Skipped meals, taken pills or other medications, caused vomiting or used laxatives? Yes No

Caffeine intake: None Coffee/tea _____ cups/day Soda _____ cans/day Chocolate _____ oz./day

SUBSTANCE USE:

Have you ever tried smoking cigarettes? Yes No If so, when was the last time? _____

Do you smoke cigarettes regularly? Yes No If so, how many cigarettes each day? _____

At what age did you start? _____ Are you interested in quitting? Yes No

Have you ever tried beer, wine or other liquor? Yes No When was the last time? _____

Do you drink alcohol regularly? Yes No If so, how often? _____

Have you ever been drunk? Yes No

- Do you use any "street drugs" such as marijuana, ecstasy and others? Yes No
 If so, which ones? _____
-
- Have you ever driven or been in a car with a driver under the influence of drugs or alcohol? Yes No
 Are you worried about the alcohol or drug use of a friend or anyone who lives in your home? Yes No
 Does anyone in your home smoke cigarettes? Yes No
 If so, do they smoke in the house? Yes No

MOOD:

- In the past few weeks, have you been depressed or extremely sad, with nothing to look forward to? Yes No
 Have you ever had thoughts about harming yourself or committing suicide? Yes No
 Would you like to get counseling about anything that is bothering you? Yes No
 Have you ever been abused: physically, emotionally or sexually? Yes No

RELATIONSHIPS:

- Do you have a friend you really like and feel you can talk to? Yes No
 Are you dating someone regularly? Yes No
 Do you have any questions about sex, pregnancy or sexually transmitted infections? Yes No
 Would you like information about preventing pregnancy? Yes No
 Would you like information about preventing sexually transmitted infections? Yes No
 Would you like information about homosexuality or bisexuality, or being gay? Yes No
 Have you ever had sexual intercourse? Yes No
 Has anyone ever forced you to do something sexual against your will? Yes No
 Do you need a birth control method now? Yes No
 Would you like to be tested now for sexually transmitted infections? Yes No

REVIEW OF SYMPTOMS: Please indicate any current symptoms you have from the list below:

- | | | |
|---|--|---|
| <i>Constitutional / Endocrine</i> | <i>Genitourinary</i> | <i>Skin</i> |
| <input type="checkbox"/> Fevers/chills/excessive sweating | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Rashes or itching |
| <input type="checkbox"/> Unexplained weight loss/gain | <input type="checkbox"/> Discharge from penis or vagina | <input type="checkbox"/> Acne |
| <input type="checkbox"/> Feeling tired a lot | <input type="checkbox"/> Pain with urination | <input type="checkbox"/> Unusual moles |
| <i>Eyes</i> | <input type="checkbox"/> Problems with periods (females) | <i>Psychiatric / Emotional</i> |
| <input type="checkbox"/> Blurry vision | <i>Neurological</i> | <input type="checkbox"/> Speech problems |
| <i>Ears / Nose / Throat</i> | <input type="checkbox"/> Headaches | <input type="checkbox"/> Anxiety/stress |
| <input type="checkbox"/> Trouble with hearing | <i>Musculoskeletal</i> | <input type="checkbox"/> Sleep problems/nightmares |
| <input type="checkbox"/> Mouth breathing/snoring | <input type="checkbox"/> Muscle/joint pain or swelling | <input type="checkbox"/> Depression/feeling sad |
| <input type="checkbox"/> Frequent runny nose | <i>Allergy</i> | <input type="checkbox"/> Nail biting |
| <input type="checkbox"/> Problems with teeth/gums | <input type="checkbox"/> Hay fever/itchy eyes | <input type="checkbox"/> Bad temper/angry outbursts/
feeling moody |
| <i>Respiratory</i> | <input type="checkbox"/> Frequent sneezing or stuffy nose | <input type="checkbox"/> Learning difficulties |
| <input type="checkbox"/> Cough/wheeze | <i>Cardiovascular</i> | <i>Blood / Lymph</i> |
| <i>Gastrointestinal</i> | <input type="checkbox"/> Tire easily with exertion | <input type="checkbox"/> Unexplained lumps |
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Easy bruising/bleeding |
| <input type="checkbox"/> Nausea/vomiting/diarrhea | <input type="checkbox"/> Palpitations (irregular heart beat) | |
| <input type="checkbox"/> Constipation | | |

Please indicate any other concerns you want to discuss today:

FAMILY HISTORY: Please indicate with a check (✓) relatives with any of the following conditions:

Medical Condition	Admin use only	Mom	Dad	Sist.	Bro.	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad
Alcoholism	33								
Asthma	5								
ADD (Attention Deficit Disorder)	80								
Bleeding problems	7								
Cancer, Breast	8								
Cancer, Colon	35								
Cancer, Melanoma	10								
Cancer, Ovary	11								
Cancer, Prostate	12								
Heart Attack/Heart Disease	13								
Depression	14								
Diabetes, on insulin shots	37								
Diabetes, not on insulin	38								
High cholesterol	22								
High blood pressure	23								
Learning disability	74								
Migraine headaches	71								
Psychiatric problem	75								
Scoliosis	76								
Seizures	27								
Stroke	28								
Substance abuse	43								
Sudden death	77								
Thyroid disorders	30								
Other:									
Other:									