



Adolescent Medical History: Parent/Guardian Form

PLEASE COMPLETE BOTH (2) PAGES

DO YOU HAVE ANY CONCERNS ABOUT YOUR ADOLESCENT'S HEALTH OR BODY? _____

PLEASE LIST ALL MEDICATIONS, VITAMINS, HERBS AND SUPPLEMENTS HE/SHE IS TAKING:

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

ALLERGIES/REACTIONS TO MEDICINES or VACCINATIONS: _____

PREVENTIVE CARE: When were his/her 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): _____

INJURY PREVENTION:

- 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 anyone in the home smoke cigarettes or use other tobacco products? Yes No

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

- Marriage
- Separation
- Divorce
- Loss of job
- Move to new neighborhood
- Change to new school
- Birth
- Serious illness
- Death
- Other changes/stresses

over

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

Medical Condition	Admin use only	Mom	Dad	Sister	Bro.	Dau.	Son	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Mom's Sister	Mom's Bro.	Dad's Sis.	Dad's Brother
Alcoholism	33														
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														
Stroke	28														
Substance abuse	43														
Thyroid disorders	30														
Other:															
Other:															

CONCERNS: Please review this list and check if you have a concern about your adolescent:

- | | |
|---|---|
| <input type="checkbox"/> Physical development | <input type="checkbox"/> Emotional development |
| <input type="checkbox"/> Weight | <input type="checkbox"/> Sleep patterns |
| <input type="checkbox"/> Diet/nutrition | <input type="checkbox"/> Amount of physical activity |
| <input type="checkbox"/> Relationships with parents and family | <input type="checkbox"/> Choice of friends |
| <input type="checkbox"/> Self image or self worth | <input type="checkbox"/> Excessive moodiness or rebellion |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Lying, stealing or vandalism |
| <input type="checkbox"/> Violence / gang activity / guns / weapons | <input type="checkbox"/> School grades / absences |
| <input type="checkbox"/> Smoking or chewing tobacco | <input type="checkbox"/> Drug use |
| <input type="checkbox"/> Alcohol use | <input type="checkbox"/> Sexual behavior |
| <input type="checkbox"/> Sexual orientation (heterosexual, gay or bisexual) | <input type="checkbox"/> Pregnancy risk |
| <input type="checkbox"/> Sexually transmitted diseases (STDs) | |

What seems to be the greatest challenge for your adolescent? _____

What about your adolescent makes you proud? _____

Is there anything you would like to discuss today privately? _____
