PROVIDENCE Medical Group

PMG Mary's Woods
17550 Provost ST STE 201 Lake Oswego
Ph: 503-872-2440 Fax: 503-513-3355

ADOLESCENT HISTORY (age 12-17)

PATIENT NAME:	DATE OF BIRTH:	AGE:	TODAY'S DATE:
MOTHER's NAME:	DATE OF BIRTH:	OCCUPATION:	
FATHER's NAME:	DATE OF BIRTH:	OCCUPATION:	
Address:			Phone:

BROTHERS: **NAME** **BIRTHDATE**

______________________________ ______________

______________________________ ______________

______________________________ ______________

SISTERS: **NAME** **BIRTHDATE**

______________________________ ______________

______________________________ ______________

______________________________ ______________

PATIENT HISTORY

Has THIS PATIENT had any…(if YES, explain below)

- ☐ Chronic or recurrent illness such as diabetes, seizures, cancer, hepatitis, mono?
- ☐ Hospitalizations? ______________________
- ☐ Surgeries? ______________________
- ☐ Bladder infection, kidney problems, undescended Testicles?
- ☐ Missing or Damaged organs? (eye, kidney, testicle)
- ☐ Problems with Heart or Blood Pressure?
- ☐ Frequent headaches, anemia, bleeding or blood clot problems?
- ☐ Chicken Pox? What Year? ______________________
- ☐ Allergies, Asthma, severe bee sting reaction?
- ☐ Learning or developmental problems?
- ☐ Speech, hearing or vision problems?
- ☐ Mental Illness or Depression?
- ☐ Drug or Alcohol use?

Does THIS Adolescent…

- ☐ Wear glasses or contact lenses?
- ☐ Wear dental bridges, braces, plates?

Is there a HISTORY of …

- ☐ Concussion, loss of consciousness, convulsions?
- ☐ Injuries to Neck, knees, ankles?
- ☐ Broken bones, joint injuries, disease, dislocation?
- ☐ Is there any medical reason why this student should not participate in sports?
- ☐ Chest pain with exercise? Wheezing? Cough?
- ☐ Dizziness or Fainting with or without exercise?
- ☐ Date of last Dental Exam? ______________________
- ☐ Date of Last Eye Exam? ______________________
- ☐ Date of last Medical Exam? ______________________
- ☐ Comments/Explanations: ______________________

Where has THIS adolescent gone for prior medical care?

IMMUNIZATION HISTORY

- ☐ Tetanus? ______________________
  - Tetanus-Diptheria (Td)? ______________________
  - Tetanus-Diptheria-Pertusis (Tdap)? ______________________
- ☐ MMR (measles, mumps, Rubella)? ______________________
- ☐ Hepatitis A: #1 ________ #2 ________
- ☐ Hepatitis B: #1 ________ #2 ________ #3 ________
- ☐ Flu Shot? ______________________
- ☐ Pneumovax? ______________________
- ☐ TB Skin Test? ______________________
  - HPV (Gardasil) ______________________
- ☐ HIV/AIDS Test? ______________________
- ☐ Chicken Pox (Varicella)?

FAMILY MEDICAL HISTORY

Have these health problems occurred in your family?
(including natural parents, brothers, sisters, and grandparents)

	Relationship
☐ Allergies/Asthma/Lung Disease?	________
☐ Tuberculosis?	________
☐ Blood Problems?	________
☐ Diabetes?	________
☐ Thyroid Disease?	________
☐ Cancer Type: ____________	________
☐ Birth Defect: ____________	________
☐ Drug / Alcohol Abuse?	________
☐ Mental illness / Depression / Suicide Attempt ____________	________
☐ Glaucoma?	________
☐ Heart Disease / Heart Attacks	________
☐ High Blood Pressure?	________
☐ High Cholesterol?	________
☐ Stroke?	________
☐ Kidney Disease?	________
☐ Migraines?	________
☐ Seizures?	________
☐ Obesity?	________

- ☐ Has any family member died suddenly at less than 50 years of age of causes other than an accident?

  ____

- ☐ Other: ______________________

Patient Symptoms Review Form: Check if Yes

- ☐ fatigue/tiredness
- ☐ weight changes
- ☐ excessive thirst
- ☐ frequent fevers
- ☐ sleep problems
- ☐ changes in vision
- ☐ eye pain
- ☐ bleeding in ears
- ☐ pain in ears
- ☐ ringing in ears
- ☐ sore mouth or tongue
- ☐ frequent hoarseness
- ☐ toothaches
- ☐ colds/sinus trouble
- ☐ bleeding gums
- ☐ irregular or fast heart beat
- ☐ chest pain with exercise
- ☐ swollen feet, ankles, hands
- ☐ breast lump(s)
- ☐ pain in breast(s) or chest
- ☐ discharge from breast(s)
- ☐ cough with phlegm
- ☐ wheeze or short of breath
- ☐ difficulty breathing
- ☐ rash, hives or itching
- ☐ change in mole or wart
- ☐ sore not healing well
- ☐ acne
- ☐ frequent tanning or sunburning
- ☐ poor appetite
- ☐ difficulty swallowing
- ☐ indigestion or heartburn
- ☐ black stool or blood in stool
- ☐ change in bowl habits
- ☐ abdominal pain
- ☐ anal itch, pain or bleeding
- ☐ constipation or diarrhea
- ☐ numbness or tingling
- ☐ loss of balance
- ☐ speech problems
- ☐ headaches
- ☐ blurred vision
- ☐ painful or swollen joints
- ☐ back pain
- ☐ pain in legs or feet
- ☐ muscle weakness
- ☐ limp
- ☐ pain, burning urination
- ☐ frequent urination
- ☐ bed wetting
- ☐ bloody or dark urine
- ☐ discharge
- ☐ sores & itching
- ☐ other bladder problems
- ☐ stiff neck
- ☐ swelling of the neck

SEXUAL HISTORY

☐Y ☐N Have you ever had sex? Age________

# of Partners________

☐Y ☐N Do you have sexual partners Now?

☐ male ☐ female ☐ both

☐Y ☐N Has anyone ever touched you against your will?

☐Y ☐N Do you think you may have been exposed to HIV?

☐Y ☐N Do you have concerns about your sexuality?

☐Y ☐N Have you ever had a sexually transmitted disease?

FEMALES ONLY (if applies)

Age of first Period:______Period every_______Days

First Day of Last Menstrual Period__________

☐Y ☐N Cramps?

☐Y ☐N Bleeding between Periods?

☐Y ☐N Unprotected intercourse since last period?

Year of last Pap Smear _______

☐Y ☐N Ever had an abnormal pap smear?

☐Y ☐N Do you use birth control? Type:______________

☐Y ☐N Do you examine your breasts regularly?

☐Y ☐N Do you have Vaginal burning, itching or discharge?

Pregnancy History:

# of Pregnancies:________ # of Live Births _______

# of Miscarriages:________# of Abortions:__________

Problems of pregnancy, labor or delivery: ______________

____

Type of Delivery: ___Vaginal ___C-Section

☐Y ☐N Are you Breastfeeding?

MALES ONLY

☐Y ☐N Do you use condoms?

☐Y ☐N Have you ever fathered a child?

☐Y ☐N Do you have burning, itching or discharge of Anus?

☐Y ☐N Do you have burning, itching or discharge of Penis?

☐Y ☐N Do you do Testicular self-examination?

HEALTH / SAFETY HISTORY

☐Y ☐N Any work, school, legal or money problems?

If yes – would you like to discuss them? ☐Y ☐N

In the Past 6 months, have you often been bothered by…

☐Y ☐N Little interest or pleasure in doing things?

☐Y ☐N Feeling down, depressed or hopeless?

☐Y ☐N Ever considered or attempted suicide?

When?________________________

☐Y ☐N Do you skip classes frequently?

☐Y ☐N Do you have trouble controlling your anger?

☐Y ☐N Do you have trouble getting along with others?

☐Y ☐N What is your grade average?______________

HEALTH HABITS

☐Y ☐N Is there alcohol/drug abuse in your home?

☐Y ☐N Do you ever drink beer, wine, wine coolers or drinks containing liquor, such as whiskey, rum, vodka or gin? How many?___________

IF you answered Yes – answer the next 4 questions…

☐Y ☐N Have you ever felt you should cut down your drinking?

☐Y ☐N Have people ever annoyed you by criticizing your drinking?

☐Y ☐N Have you ever felt bad or guilty about your drinking?

☐Y ☐N Have you ever taken a drink first thing in the morning (eye opener) to steady your nerves or get rid of hangover?

☐Y ☐N Do you smoke?: if Quit – When?________________

☐Y ☐N Do you chew tobacco?: If Quit – When?____________

☐Y ☐N Are you interested in quitting?__________________

☐Y ☐N Do you use “street” drugs (marijuana/cocaine)?

☐Y ☐N How many times to you exercise in a week? __________

DIETARY

☐Y ☐N Do you usually eat a variety of meats (or other proteins), Fruits, vegetables, milk and grains?

☐Y ☐N Do you take Vitamins?

☐Y ☐N Have you ever dieted?

☐Y ☐N Are you on a special Diet?

☐Y ☐N Are you satisfied with your current weight?

SAFETY

☐Y ☐N Do you wear seatbelts when driving a car?

☐Y ☐N Do you wear a helmet on a Bike, Skates or Motorcycle?

☐Y ☐N Do you have a working smoke detector at home?

☐Y ☐N Is there a gun in your home?

☐Y ☐N Is there verbal or physical fighting in your home?

☐Y ☐N Have you ever been hit, slapped, kicked or otherwise physically hurt by someone?

Currently taking any Medications? ☐**Y** (list below) ☐**N**

Medication	Dose	How many times per day?	When Started?

Drug Allergies or Reactions? ☐**Y** (list below) ☐**N**