Health History Questionnaire

PROVIDENCE Health & Services

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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)

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

Does THIS Adolescent…..

Y N Wear glasses or contact lenses
Y N Wear dental bridges, braces, plates

Is there a HISTORY of…

Y N Concussion, loss of consciousness, convulsions
Y N Injuries to Neck, knees, ankles
Y N Broken bones, joint injuries, disease, dislocation
Y N Is there any medical reason why this student should not participate in sports
Y N Chest pain with exercise? Wheezing? Cough?
Y N Dizziness or Fainting with or without exercise

Date of last Dental Exam? _____

Date of Last Eye Exam? _____

Date of last Medical Exam? _____

Comments/Explanations: _____

_____

_____

_____

_____

IMMUNIZATION HISTORY

Y N Tetanus _____
Y N MMR (Measles, Mumps, Rubella) _____
Y N Hepatitis A: #1_____ #2_____
Y N Hepatitis B: #1_____ #2_____ #3_____
Y N Flu Shot? _____
Y N Pneumovax _____
Y N TB Skin Test _____
Y N HIV/AIDS Test _____
Y N Chicken Pox (Varicella) _____

FAMILY MEDICAL HISTORY

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

Relationship

Y N Allergies/Asthma/Lung Disease _____
Y N Tuberculosis? _____
Y N Blood Problems? _____
Y N Diabetes? _____
Y N Thyroid Disease? _____
Y N Cancer Type: _____ _____
Y N Birth Defect: _____ _____
Y N Drug / Alcohol Abuse? _____
Y N Mental illness / Depression / Suicide Attempt _____
Y N Glaucoma? _____
Y N Heart Disease / Heart Attacks _____
Y N High Blood Pressure? _____
Y N High Cholesterol? _____
Y N Stroke? _____
Y N Kidney Disease? _____
Y N Migraines? _____
Y N Seizures? _____
Y N Obesity? _____
Y N Has any family member died suddenly at less than 50 years of age of causes other than an accident?

Other: _____

Patient Symptoms Review Form: Mark Y or N

Y N Fatigue/tiredness	Y N Irregular or fast heart beat	Y N Poor appetite	Y N Painful or swollen joints
Y N Weight changes	Y N Chest pain with exercise	Y N Difficulty swallowing	Y N Back pain
Y N Excessive Thirst	Y N Swollen feet, ankles, hands	Y N Indigestion or heartburn	Y N Pain in legs or feet
Y N Frequent fevers	Y N Breast lump(s)	Y N Black stool or blood in stool	Y N Muscle weakness
Y N Sleep problems	Y N Pain in breast(s) or chest	Y N Change in bowl habits	Y N Limp
Y N Changes in vision	Y N Discharge from breast(s)	Y N Abdominal pain	Y N Pain, burning urination
Y N Eye pain	Y N Cough with phlegm	Y N Anal itch, pain or bleeding	Y N Frequent urination
Y N Bleeding in ears	Y N Wheeze or short of breath	Y N Constipation or diarrhea	Y N Bed wetting
Y N Pain in ears	Y N Difficulty breathing	Y N Numbness or tingling	Y N Bloody or dark urine
Y N Ringing in ears	Y N Rash, hives or itching	Y N Loss of balance	Y N Discharge
Y N Sore mouth or tongue	Y N Change in mole or wart	Y N Speech problems	Y N Sores & itching
Y N Frequent hoarseness	Y N Sore not healing well	Y N Headaches	Y N Other bladder problems
Y N Toothaches	Y N Acne	Y N Blurred vision	Y N stiff neck
Y N Colds/sinus trouble	Y N Frequent tanning or sun burning	Y N Swelling of the neck	Y N Bleeding gums

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**