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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)**

- ☐ 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**