ADOLESCENT HEALTH HISTORY

Appropriate for 13 to 18 years

NAME: _____ BIRTHDATE: _____

☐ MALE ☐ FEMALE

PERSON COMPLETING THIS HISTORY: _____ TODAY'S DATE: _____

HEIGHT _____ PRESENT WEIGHT _____ LBS.

MEDICAL HISTORY:

Have you ever had or do you now have any of the problems listed below?

Yes	No		Yes	No		Yes	No	
☐	☐	AIDS	☐	☐	Depression	☐	☐	Mononucleosis
☐	☐	Anemia (low blood)	☐	☐	Epilepsy	☐	☐	Phlebitis (Blood Clot in Vein
☐	☐	Other blood disorder	☐	☐	Eye disease	☐	☐	Sexually transmitted disease
☐	☐	Arthritis	☐	☐	Heart trouble			(Gonorrhea, Herpes, Syphili
☐	☐	Asthma	☐	☐	Hepatitis/Jaundice	☐	☐	Sickle Cell
☐	☐	Back trouble	☐	☐	Hemorrhoids	☐	☐	Sinus Problems
☐	☐	Bleeding tendencies	☐	☐	Hernia	☐	☐	Stomach trouble/Ulcers
☐	☐	Bronchitis/Pneumonia	☐	☐	High blood pressure	☐	☐	Thyroid problems
☐	☐	Cancer/Tumor	☐	☐	Hypoglycemia	☐	☐	German measles (Rubella)
☐	☐	Colitis/Bowel problems	☐	☐	Kidney/Bladder trouble	☐	☐	Tuberculosis
☐	☐	Convulsions (Seizures)	☐	☐	Migraine headaches	☐	☐	Diabetes (Sugar)

☐ ☐ Have you ever had a positive TB test? If yes, when? _____

☐ Other: _____ Year of last **Tetanus** shot: _____

If any "Yes" or "Other" is checked, please explain: _____

_____

List any surgeries (operations)/hospitalizations: _____

_____

List any serious accidents: _____

_____

Have you had trouble with:

Yes	No		Yes	No		Yes	No	
☐	☐	Allergies	☐	☐	Chronic cough	☐	☐	Constipation
☐	☐	Abdominal pain	☐	☐	Coughing up blood	☐	☐	Diarrhea
☐	☐	Vision	☐	☐	Chest pain	☐	☐	Change in bowel habits
☐	☐	Hearing	☐	☐	Sleeping	☐	☐	Rectal bleeding
☐	☐	Excessive bleeding	☐	☐	Dizziness/Fainting	☐	☐	Heartburn/Indigestion
☐	☐	Headaches	☐	☐	Fatigue/Tiredness	☐	☐	Numbness/Tingling
☐	☐	Shortness of breath	☐	☐	Confusion/Loss of memory			

☐ Other _____

If any "Yes" or "Other" is checked please explain: _____

List any allergic reactions or sensitivities to medicine: _____

_____

List any medications you are currently taking: _____

_____

- OVER -

ADOLESCENT HEALTH HISTORY -- PAGE 2

Have you had any of the following illnesses?

☐ Chickenpox ☐ Smallpox ☐ German Measles ☐ Hard Measles
☐ Mumps ☐ Scarlet Fever ☐ Strep Throat ☐ Diphtheria

WOMEN:

Check if you have had problems with:

☐ Breast Lumps
☐ Discharge from Nipples
☐ Vaginal Discharge
☐ Uterine Infection
☐ Menstrual Period
☐ Bleeding between periods
☐ Mother took DES

Age when you had your first period _____
Average number of days of flow _____
Length of time between periods _____
Number of pregnancies _____
Number of live births _____
Number of miscarriages _____
Number of abortions _____
Number of living children _____
Do you think you are pregnant now? ☐ Yes ☐ No

Date of last Pap smear _____
Have you ever had an abnormal Pap smear? ☐ Yes ☐ No
Do you regularly perform self breast exams? ☐ Yes ☐ No
Are you sexually active? ☐ Yes ☐ No

MEN:

Check if you have had problems with:

☐ Urination ☐ Testicular Pain or Swelling

Do you regularly perform testicular exams? ☐ Yes ☐ No Are you sexually active? ☐ Yes ☐ No

FAMILY HISTORY:

Check if any member of your immediate family has had any of the following:

☐ Alcoholism ☐ Anemia ☐ Bleeding Disorder ☐ Cancer ☐ Diabetes ☐ Epilepsy ☐ Glaucoma
☐ Gout ☐ Heart Disease ☐ High Blood Pressure ☐ Mental Illness ☐ Stroke ☐ Suicide ☐ Tuberculosis

If a parent, brother or sister has died, please list their age(s) _____ and cause(s) of death: _____

_____ _____

SOCIAL HISTORY:

Do you smoke? ☐ Yes ☐ No If so, how much? Cigarettes _____ /packs per day _____Cigars per day ____
Do you drink... Liquor? ☐ Yes ☐ No Beer? ☐ Yes ☐ No If so, how much? _____
Do you use illegal drugs? ☐ Yes ☐ No If so, what kind, how much? _____
Have you ever been treated for alcohol or substance abuse? _____ ☐ Yes ☐ No If so, how long ago? _____
Do you drink caffeinated beverages (coffee, cola)? _____ ☐ Yes ☐ No If so, how much? _____
How often do you exercise? _____ What kind? _____
Do you eat a low fat diet? ☐ Yes ☐ No Do you wear seat belts when you are in a car? ☐ Yes ☐ No
Do you wear a helmet when riding a bike or motorcycle? ☐ Yes ☐ No
Do you have smoke detectors in your home? ☐ Yes ☐ No

If any of the following are checked "Yes", please describe: _____

_____

	Yes	No
Are you often dissatisfied with your life?	☐	☐
Are you tense or fearful?	☐	☐
Are you sad or depressed?	☐	☐
Do you ever feel like ending it all?	☐	☐
Do you have any other concerns not previously identified?	☐	☐

_____

Physician Signature Date

*Reviewed*_____ *Date*_____ *Reviewed*_____ *Date*_____ *Reviewed*_____ *Date*_____
*Reviewed*_____ *Date*_____ *Reviewed*_____ *Date*_____ *Reviewed*_____ *Date*_____