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Adolescent New Patient Health History – 12-17 years

Name _____ **Date of Birth**___/___/_____ **Gender** _____

Current Medical Concerns (what you would like to talk about today):

1. (most important)_____
2. _____
3. _____

Please list any ALLERGIES you have has to medications:

NAME OF MED: Reaction

_____

_____

Please list any MEDICATIONS you currently take, including Over the Counter Medications, Herbal Supplements, or Vitamins:

NAME OF MED Dose Directions (How often given)

_____

_____

_____

Immunizations

Do you follow the recommended CDC vaccination schedule? NO YES

Please explain if altering schedule:_____

Have you ever been hospitalized? Yes / No **If yes, please explain below:**

_____

_____

Please circle any surgeries you have had: Heart Ear Tubes Tonsils/Adenoids Appendix

Circumcision Frenulectomy (tongue clipping) Eye Surgery Hernia Repair, type: _____

Other: _____

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Name (page 2) _____

Personal Health History

ADHD or ADD	No ☐	Yes ☐	Endometriosis	No ☐	Yes ☐
Allergies/Hay fever	No ☐	Yes ☐	GYN Problems (Ovaries/Uterus/Menstrual)	No ☐	Yes ☐
Anemia	No ☐	Yes ☐	HIV	No ☐	Yes ☐
Anesthesia Complications	No ☐	Yes ☐	Heart Problems	No ☐	Yes ☐
Anxiety Disorder or Recurrent Anxiety	No ☐	Yes ☐	High Blood Pressure	No ☐	Yes ☐
Asthma	No ☐	Yes ☐	Kidney or Bladder Problems	No ☐	Yes ☐
Autism Spectrum Disorder	No ☐	Yes ☐	Liver Disease	No ☐	Yes ☐
Birth Defects or Inherited Disease	No ☐	Yes ☐	Migraines	No ☐	Yes ☐
Blood Transfusion	No ☐	Yes ☐	Muscle, Joint, or Bone Problems	No ☐	Yes ☐
Cancer	No ☐	Yes ☐	Reflux/GERD	No ☐	Yes ☐
Chicken Pox	No ☐	Yes ☐	Seizures/Epilepsy	No ☐	Yes ☐
Clotting Problems - Bleed too much or History of Blood Clots	No ☐	Yes ☐	Skin problems	No ☐	Yes ☐
Developmental or Behavioral Disorders	No ☐	Yes ☐	Stomach Ulcers or Swallowing Problems	No ☐	Yes ☐
Diabetes	No ☐	Yes ☐	Thyroid Problems	No ☐	Yes ☐
Domestic Violence	No ☐	Yes ☐	Tuberculosis or Positive TB Test	No ☐	Yes ☐
Ear Infections - Chronic	No ☐	Yes ☐	Vision or Eye Problems	No ☐	Yes ☐
Ear or Hearing Problems	No ☐	Yes ☐	Other	No ☐	Yes ☐
Eczema	No ☐	Yes ☐		No ☐	Yes ☐

Does anyone smoke at home? NO YES **Who?**_____

Parents' Marital Status? _____

What is your current living arrangement?

House Apartment Foster Care Home Other (specify) _____

Who does child live with? (Circle all that apply) Mother Father Step-Parent Grandparent Aunt/Uncle

Foster Family Sibling(s) Other _____

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Name (page 3) _____

Nutrition

Any special dietary needs (i.e. Gluten Free)? NO YES _____

Safety

Do you wear seatbelts in the car always? NO YES

Do you use a helmet when riding a bike/scooter? NO YES

Is there anyone in the house who uses recreational drugs? NO YES

Does your home environment feel safe? NO YES

Do you have concerns about meeting basic needs (food/clothing/shelter?) NO YES

Education and Activity

Grade in School _____ Name of School_____

School Performance: AT Grade Level Above Grade Level Needs Assistance

Sports? Yes / No _____ Hobbies? Yes / No _____

Any problems with bullying? Yes / No

Screen Time (TV/Computer/Phone) Daily (on average)?

None Less than one hour 1-2 hours 3 hours or more

How much time do you spend outside each day (on average)?

None A few minutes One hour daily More than one hour daily

Other Questions

Do you smoke cigarettes?

Never tried Tried once or twice Sometimes YES

Do you drink alcohol?

Never tried Tried once or twice Sometimes YES

Sexual Health (Who is filling out this portion of the form?) _____

Sexually Active? NO YES If Yes, Number of TOTAL Partners (Past and present): _____

If YES, do you use CONDOMS always? NO YES

Do you also use another form of Birth Control or Contraception? NO YES

Females Only: Menstrual Periods started at age _____ LMP _____

Females Only: Have you (the child/teen) ever been pregnant? NO YES

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Name (page 4) _____

Family Health History

Is your child adopted? Yes / No (If NO, please complete section below)

	Father	Mother	Grandmother	Grandfather	Brother	Sister	Aunt	Uncle
ADHD								
Alzheimer's Disease								
Alcoholism								
Aneurysm								
Anxiety or Depression								
Arthritis								
Asthma								
Blood Disorder								
Cancer								
Diabetes								
Emphysema/COPD								
Hereditary Disorder								
High Cholesterol								
High Blood Pressure								
Kidney Disease								
Liver Disease								
Manic-Depression or Bipolar								
Migraines								
MI = Heart Attack								
Osteoporosis								
Seizures								
Skin Cancer								
Stroke								
Sudden Cardiac Death								
Thyroid Disorder								

Thank you!