Adolescent Health History Form

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Use Form for Ages 11 to 17 Years

Adolescent's Personal Information

Patient Last Name: First Name: Middle Initial:

Date Of Birth: *(month/day/year)* Age:

Previous Doctor?

Current Health Concerns:

List Current Medications (Including: Vitamins, Herbs, Supplements, and Birth Control)

Name / Dose / How Many Times Per Day:

Current Allergies / Reactions to Medications or Vaccinations:

Major Health Problems / Hospitalizations / Operations / Broken Bones / Severe Pain Information

Please Describe any Major Health Problems and Related Dates:

Please List any Hospitalizations / Operations and Related Dates:

Please List any Broken Bones and / or Severe Pain:

Social / School History Information

Current Grade: [ ] Average School Grades: [ ] Name of School: [ ]

Dating? ☐ Yes ☐ No Sexually Active? ☐ Yes ☐ No Using Birth Control? ☐ Yes ☐ No

Would You Like More Information About Birth Control? [ ]

Any Concerns about School performance? [ ]

Any Concerns about Relationships with: Teachers? ☐ Yes ☐ No Students? ☐ Yes ☐ No

Sports / Exercise: Type? [ ] How Often? [ ] How Long? [ ]

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Immunizations / Infectious Diseases Information

Please bring immunizations records with you to the appointment.

Has Your Child Had? ☐ Chickenpox ☐ Measles ☐ Mumps ☐ Rubella ☐ Meningitis ☐ Tuberculosis

☐ Hepatitis B ☐ Influenza ☐ Pneumonia Other Disease? [ ]

Family History Information

Please check all that apply to your family history.

☐ Alcoholism / Drug Abuse ☐ High Cholesterol ☐ Psychiatric Disorders

☐ Heart Disease / Stroke ☐ Cancer ☐ Depression / Suicide

☐ High Blood Pressure ☐ Diabetes ☐ Inherited / Genetic Diseases

Prevention / Safety Information

What is Your Dentist's Name? [ ] Date of Last Exam? [ ]

Do You or Anyone in Your Household Use:

Tobacco Products? ☐ No ☐ Me ☐ Household Member

Drink Alcohol? ☐ No ☐ Me ☐ Household Member

Use Illegal Drugs? ☐ No ☐ Me ☐ Household Member

Do You Have a Gun In Your Home? ☐ Yes ☐ No

If Yes, Is it Unloaded and Out of Reach? ☐ Yes ☐ No

Do You Regularly Use Helmets For (Bikes / Boards / ATV's / Motorcycles)? ☐ Yes ☐ No

Do You Use Seat Belts When Riding In Or Driving A Car? ☐ Yes ☐ No

Review of Symptoms Information

Other Concerns? Check All That Apply

- ☐ Physical Development
- ☐ Family Relationships
- ☐ Excessive Moodiness / Rebellion
- ☐ Smoking / Chewing Tobacco
- ☐ Drug Use
- ☐ Weight
- ☐ Emotional Development
- ☐ Diet / Nutrition
- ☐ Alcohol Use
- ☐ Pregnancy Risk
- ☐ Sexual Behavior
- ☐ Depression
- ☐ Sleep Patterns
- ☐ Amount of Physical Activity
- ☐ Self Image / Self Worth
- ☐ Lying / Stealing / Vandalism
- ☐ Sexually Transmitted Diseases
- ☐ Sexual Orientation

Review of Symptoms Information

Please check all current symptoms that adolescent is experiencing.

General

- ☐ Fever / Chills / Excessive Sweating
- ☐ Unexplained Weightloss

Eyes

- ☐ Squinting / Cross Eyes
- ☐ Tires Easily with Exercise

Heart / Cardiovascular

- ☐ Shortness of Breath
- ☐ Fainting
- ☐ Chest Pain with Exercise

Ears / Nose / Throat

- ☐ Mouth Breathing / Snoring
- ☐ Bad Breath
- ☐ Frequently Runny Nose
- ☐ Problems with Teeth / Gums
- ☐ Unusually Loud Voice / Hard of Hearing

Lungs / Respiratory

- ☐ Cough / Wheezing
- ☐ Chest Pain

Gastrointestinal

- ☐ Nausea / Vomiting / Diarrhea
- ☐ Constipation
- ☐ Blood in Bowel Movement

Genitourinary

- ☐ Bedwetting
- ☐ Pain with Urination
- ☐ Discharge: Penis or Vagina

Musculoskeletal

- ☐ Muscle / Joint Pain

Skin

- ☐ Rashes / Unusual Moles

Allergy

- ☐ Hay Fever / Itchy Eyes

Neurological

- ☐ Headaches
- ☐ Weakness
- ☐ Clumsiness
- ☐ Speech Problems

Psychiatric / Emotional

- ☐ Anxiety / Stress
- ☐ Sleep Problems / Nightmares
- ☐ Depression
- ☐ Nail Biting / Thumb Sucking
- ☐ Bad Temper / Holding Breath

Blood / Lymph System

- ☐ Unexplained Lumps
- ☐ Easy Bruising / Bleeding