Primary Care Health Partners

ADOLESCENT HEALTH HISTORY

(Use for ages 11-20 years)

Today's Date: _____

Patient Name: _____ Date of Birth: _____ Age: _____

PAST MEDICAL HISTORY

Previous doctor: ☐ None ☐ Yes (name)_____

Allergies/reactions to medicines or vaccines: _____

Current Medications: (including vitamins, herbs, supplements, birth control pills)

Name	Dose	How many times per day	When started

Major Medical Problems: ☐ None ☐ Yes, (list) _____

Hospitalizations/ Operations: ☐ None ☐ Yes, (list) _____

Broken bones/Severe Injuries: ☐ None ☐ Yes, (list) _____

REVIEW OF SYSTEMS

Please check (✓) any current problems your child has on the list below:

General
- ☐ fevers/chills/excessive sweating
- ☐ unexplained weight loss/gain

Eyes
- ☐ squinting/cross eyes

Ears/Nose/Throat
- ☐ unusually loud voice/hard of hearing
- ☐ mouth breathing/snoring
- ☐ bad breath
- ☐ frequently runny nose
- ☐ problems with teeth/gums

Heart /Cardiovascular
- ☐ tires easily with exercise
- ☐ shortness of breath
- ☐ fainting
- ☐ chest pain with exercise

Lungs/Respiratory
- ☐ cough/wheeze
- ☐ 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
- ☐ problems with sleep/nightmares
- ☐ depression
- ☐ nail biting/thumb sucking
- ☐ bad temper/breath holding/jealousy

Blood/Lymph
- ☐ unexplained lumps
- ☐ easy bruising/bleeding

SOCIAL/SCHOOL HISTORY

Current grade: _____ Name of School: _____

Concerns about school performance? ☐ No ☐ Yes, _____

Concerns about relationships with teachers? ☐ No ☐ Yes, _____ Students? ☐ No ☐ Yes, _____

School grades: _____ Best friend? ☐ No ☐ Yes Many friends? ☐ No ☐ Yes Dating? ☐ No ☐ Yes

Sexually active? ☐ No ☐ Yes Using birth control? ☐ No ☐ Yes Would like more information? ☐ No ☐ Yes

Involved in activities/sports/exercise? ☐ No ☐ Yes (list) _____

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FAMILY HISTORY

Please indicate family members (mother, father, sister, brother, aunt, uncle, grand parent)

Alcoholism _____ Heart attack _____ High cholesterol _____ Stroke _____

Cancer _____ High blood pressure _____ Depression/suicide _____ Diabetes _____

In the past year, have there been any changes in your family? (check all that apply)

☐ Marriage ☐ Separation ☐ Divorce ☐ Move to new neighborhood ☐ Change to new school ☐ Serious illness

☐ Loss of job ☐ Death ☐ Birth ☐ Other changes/stresses _____

Who lives at home with you?

Name	Age	Relationship

IMMUNIZATION/INFECTIOUS DISEASE

Did you bring your child's immunization record with you today?

☐ Yes ☐ No ☐ Will bring to next appointment ☐ Records with another care provider (name)_____

Has your child had: ☐ Chicken Pox ☐ Measles ☐ Mumps ☐ Rubella ☐ Tuberculosis (TB) ☐ Hepatitis B

☐ Meningitis ☐ Pneumonia ☐ Influenza (flu) ☐ Other disease _____

PREVENTION/SAFETY

What is your dentist's name? _____ Date of last dental exam: _____

Do you or does anyone in your home:

Use tobacco products? ☐ No ☐ Me ☐ Household member Type: _____ Amount: _____

Drink alcohol? ☐ No ☐ Me ☐ Household member Type: _____ Amount: _____

Use illegal drugs? ☐ No ☐ Me ☐ Household member Type: _____ Amount: _____

Does your home have smoke detectors? ☐ No ☐ Yes

Do you have a gun in your house? ☐ No ☐ If Yes, is it unloaded and out of reach? ☐ No ☐ Yes

Do you regularly use:

Helmets for bikes/boards/ATVs/motorcycles? ☐ No ☐ Yes

Seat belts when riding or driving a car? ☐ No ☐ Yes

OTHER CONCERNS

Please review this list and check any concerns you have about the patient

☐ Physical development	☐ Emotional development	☐ Sleep patterns
☐ Weight	☐ Diet/Nutrition	☐ Amount of physical activity
☐ Relationship with parents and family	☐ Choice of friends	☐ Self image/self worth
☐ Excessive moodiness or rebellion	☐ Depression	☐ Lying, stealing, vandalism
☐ Violence/gangs/guns/weapons	☐ School grades/absences	☐ Drug use
☐ Smoking/chewing tobacco	☐ Alcohol use	☐ Sexual behavior
☐ Sexual orientation (heterosexual, gay)	☐ Pregnancy risk	☐ Sexually transmitted diseases (STDs)

What is the greatest challenge for you/your child? _____

What about you/your adolescent makes you proud? _____

Is there anything you would like to discuss in private today? _____

Signature of person completing this form: _____