HEALTH HISTORY
(ADOLESCENT AGE 13-18)

Name:_____ Date of Birth:_____ Age:_____

Sex: M F Grade in School:_____ Parent/Guardian:_____

MEDICAL HISTORY (check if you currently have or have had in the past)

General:
__Fever/chills/excessive sweating
__Unexplained weight loss/gain

Eyes:
__Vision problems

Ears/Nose/Throat:
__Earache
__Ear Drainage
__Hearing loss
__Allergies/Hay fever
__Sinus problems
__Nosebleeds

Heart/Cardiovascular:
__Chest pain
__Heart Murmur
__Irregular/rapid heart beat

Lungs/Respiratory:
__cough/wheeze
__Pertussis(whooping cough)
__Pneumonia
__Asthma
__Shortness of breath

Gastrointestinal:
__Constipation
__Diarrhea
__Vomiting
__blood in bowel movement

__Diabetes
__Cancer Type:_____
__Eating disorder
__HIV

Skin:
__Rash
__Unusual Moles
__Chicken Pox

Neurological:
__Headaches
__Seizures/Epilepsy
__Fainting
__Dizziness

Blood/Lymph:
__Anemia
__Unexplained lumps
__Easy bruising/bleeding

Psychiatric/Emotional:
__Anxiety/Stress
__Depression
__Sleep problems/Nightmares

Genitourinary:
__Blood in urine
__Painful urination
__Bedwetting

Males:
__Pain in testicles
__Do you do testicular exams? Y N
__Penis discharge
__Sores on penis

Females:
Age period started_____
How often is your period_____
How many days does it last_____
Have you ever been pregnant Y N
Do you do self breast exams? Y N

Current Medications

Please list all prescription and over the counter medications you are taking

Medication	Dose	Reason	How Long

Allergies

Medications:_____ Foods:_____

Other:_____

Hospitalizations/Surgeries

Hospital	Reason	Date	Physician

FAMILY HISTORY:

Please check if any blood relatives have had any of the following:

__Arthritis __Asthma __Cancer Type:_____

__Diabetes __Heart Disease __Hypertension __Tuberculosis

__Glaucoma __Epilepsy __Kidney Disease __Stroke

__Thyroid Disease __Mental Illness __Chemical dependency

PRENATAL HISTORY:

Where were you born?_____ Were you premature? Y N

Did your mother have any pregnancy complications? Y N If yes, please explain_____

Did you have any complications at birth? Y N If yes, please explain_____

SELFCARE/HEALTH HABITS: (The following includes questions regarding current health habits, sexuality and use of drugs and alcohol, please answer honestly, all information is considered confidential and will not be shared, without your permission, to anyone besides your healthcare provider)

1. Are you often sad/depressed?	Yes	No	
2. Are you often anxious/tense?	Yes	No	
3. Do you feel something is wrong with your weight?	Yes	No	
4. Do you have nutritional concerns?	Yes	No	
5. Are you involved in sports/exercise?	Yes	No	
6. Have you ever had thoughts of suicide?	Yes	No	
7. Do you have troubles at school?	Yes	No	
8. Have you ever been in trouble with the police?	Yes	No	
9. Is there violence or abuse in your home?	Yes	No	
10. Have you ever been touched in a way that made you feel uncomfortable?	Yes	No	
11. Have you ever been physically/emotionally/sexually abused?	Yes	No	
12. Do you have a boyfriend or girlfriend?	Yes	No	
13. Are you sexually active?	Yes	No	
14. If so, do you use birth control?	Yes	No	Type:_____
15. Do you smoke cigarettes?	Yes	No	
16. Do you chew tobacco?	Yes	No	
17. Do you drink alcohol?	Yes	No	
18. Do you use illegal drugs, or prescription drugs that were not prescribed to you?	Yes	No	Type:_____
19. Do you feel that you have a problem with drugs or alcohol?	Yes	No	
20. Has anyone ever told you that you have a problem with drugs or alcohol?	Yes	No	
21. Do you feel anyone in your family has a problem with drugs or alcohol?	Yes	No	
22. Do you have any questions regarding birth control, drugs, alcohol or any other concerns regarding your health?	Yes	No	

Thank you for taking the time to complete this form. The information provided will be helpful in planning your healthcare needs.

Person completing form:_____Date:_____

Relationship if not patient:_____

Provider Signature:_____