

13-18 ADOLESCENT MEDICAL HISTORY

Name _____ Date of Birth _____ Today's Date _____

What is your chief concern today? _____

MEDICATIONS: List all prescription and over the counter medications that you are currently taking regularly. Include vitamin, herbs and other supplements. _____

<p>ALLERGIES: Medications you are allergic to or have reactions to:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>List any non-medication allergies:</p> <p>_____</p>	<p>IMMUNIZATIONS: Please list dates of last shot</p> <p>Tetanus _____</p> <p>Pneumonia _____</p> <p>Hepatitis B _____ Hepatitis A _____</p>
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RISK FACTORS:

Do you smoke? Current Quit Never If quit, when _____ Passive smoke exposure: Yes No

Do you use any illegal drugs? Yes No If yes, please list _____

Are you sexually active? Yes No If yes, have you had more than 5 partners? Yes No

Do you have sex with: Men Women Both

How many caffeinated drinks do you have each day? _____

Do you have a family history of heart attacks at a younger age? Female < 65: Yes No Male < 55: Yes No

Do you drink alcohol? Yes No If yes, type of alcohol: _____ Drinks per day: _____

Exercise: Yes No Times per week: _____ Type of exercise: _____

Seatbelt use: 100% 75% 50% 25% 0%

Sun exposure: Frequently Occasionally Rarely Remote

PERSONAL MEDICAL HISTORY: Circle if you've had		
Anemia Asthma Bladder Infections Blood Clots Broken Bones Cancer Type: Colitis Or Other Bowel Disease Depression Diabetes Drug Or Alcohol Problems	Eczema Hay fever Head Injuries Hives Jaundice Liver Disease Joint Dislocations Kidney Disease Meningitis Mental Disorder	Migraine Headaches Pneumonia Polio Rheumatic Fever Seizure Or Epilepsy Sexually Transmitted Diseases Stomach Ulcer or Reflux Stroke Thyroid Problems

SURGERIES: Check if you have had: Tonsillectomy Adnoidectomy Appendectomy

List any other surgeries:

Type _____ Year _____

Type _____ Year _____

Type _____ Year _____

Type _____ Year _____

Type _____ Year _____

Type _____ Year _____

Type _____ Year _____

Type _____ Year _____

HOSPITALIZATIONS (Other than for surgery) Please list:

Date _____ Reason _____
Date _____ Reason _____
Date _____ Reason _____
Date _____ Reason _____
Date _____ Reason _____

TESTS / EXAMS: Check and indicate year

Physical or Sports exam Year _____ Eye Exam Year _____
 Other (list) _____ Year _____

FOR FEMALES ONLY

Date of last period: _____
Number of pregnancies: _____ Live births: _____ Miscarriages: _____ Living children: _____
How much milk do you drink? _____ Do you take calcium? YES NO
Is there anything else about your medical history that you would like your doctor to know? _____

Please list other healthcare providers you are receiving care from (indicate name & reason): _____

FAMILY HISTORY:

RELATIONSHIP	NAME	BIRTH YEAR (if living)	AGE AT DEATH	CAUSE OF DEATH
Father				
Mother				
Brothers & Sisters				
Children				

If there is a family history of any of the following, circle the relationship of any that applies:

	Relationship		
Alcohol or other substance abuse	Mother	Father	Sibling
Asthma	Mother	Father	Sibling
Breast Cancer	Mother	Father	Sibling
Heart Disease	Mother	Father	Sibling
Colon Cancer	Mother	Father	Sibling
Stroke	Mother	Father	Sibling
Deafness	Mother	Father	Sibling
Depression/Suicide/Mental illness	Mother	Father	Sibling
Diabetes	Mother	Father	Sibling
Epilepsy/Seizures	Mother	Father	Sibling
Hepatitis (type _____)	Mother	Father	Sibling
High blood pressure	Mother	Father	Sibling
High Cholesterol	Mother	Father	Sibling
Osteoporosis	Mother	Father	Sibling
Ovarian Cancer	Mother	Father	Sibling
Prostate Cancer	Mother	Father	Sibling
Tuberculosis	Mother	Father	Sibling

Other significant family history: _____

SOCIAL HISTORY:

School: _____ Grade: _____

Are you adopted? Yes No

Names and dates of birth of persons *living in your household*, and their relationship to you: _____

Life changes (new siblings, divorce, death) in the family in the past 12 months: _____

Do you have any religious practices that would affect how we medically care for you? YES NO

REVIEW OF SYSTEMS: Circle any/all of the following symptoms that you are **CURRENTLY** concerned about:

GENERAL HEALTH

- No complaints
- Fever
- Chills
- Sweats
- Loss of appetite
- Fatigue
- Weakness
- Don't feel well
- Weight change
- Wake up tired
- Day fatigue/sleepy
- Snoring
- Sleep problems

EYE

- No complaints
- Blurring
- Double vision
- Irritation/Itching
- Redness
- Discharge
- Vision loss
- Eye pain
- Light hurts eyes

EAR/NOSE/THROAT

- No complaints
- Earache
- Ear discharge
- Ear ringing/buzzing
- Decreased hearing
- Nasal congestion
- Nasal discharge
- Postnasal drip
- Nosebleeds
- Sore throat
- Hoarseness
- Itching nose/eyes
- Sneezing

CARDIOVASCULAR

- No complaints
- Chest discomfort
- Pounding/racing heart
- Lightheadedness
- Passing out/fainting
- Shortness of breath with activity
- Shortness of breath lying down
- Sudden waking with shortness of breath
- Swelling in feet/ankles
- Leg pain with exercise

RESPIRATORY

- No complaints
- Coughing
- Wheezing
- Shortness of breath at rest
- Coughing up phlegm
- Coughing up blood
- Painful breathing

GASTROINTESTINAL

- No complaints
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Change in bowel habits
- Abdominal pain
- Dark black stools
- Red blood in stools
- Gas/bloating
- Indigestion/heartburn
- Swallowing problems
- Painful swallowing
- Jaundice

GENITAL/URINARY

- No complaints
- Painful urination
- Blood in the urine
- Frequency
- Genital sores
- Males:
 - Penis discharge
 - Urinating more often
 - Decreased stream
- Females:
 - Urgency
 - Hesitancy
 - Vaginal Discharge
 - Missed periods
 - Abnormally Heavy periods
 - Abnormal Vaginal bleeding
 - Pelvic Pain

MUSCULOSKELETAL

- No complaints
- Neck pain
- Upper back pain
- Lower back pain
- Joint pain
- Joint swelling
- Joint stiffness
- Muscle cramps
- Muscle weakness
- Pain radiating down leg

DERMATOLOGY

- No complaints
- Rash
- Itching
- Dryness
- Changing lesions
- Non-healing sores

NEUROLOGY

- No complaints
- Weakness of a limb
- Numbness/tingling in arms/legs
- Seizures
- Tremors
- Dizziness
- Loss of vision
- Balance problems
- Frequent headaches
- Severe headaches
- Difficulty speaking
- Difficulty swallowing
- Clumsiness
- Confusion
- Memory loss

PSYCHIATRIC

- No complaints
- Feel down, depressed
- Feel overwhelmed
- Lack joy in my life
- Little interest/pleasure in doing things
- Anxious or worried
- Excessive sleep
- Inadequate sleep
- Change in appetite
- Difficult to concentrate
- Thoughts of suicide
- Hallucinations
- Fears

ENDOCRINE

- No complaints
- Get cold easily
- Overheat easily
- Drinking more fluids than usual
- Eating more than usual
- Urinating more than usual
- Unintended weight change

HEMATOLOGY

- No complaints
- Abnormal bruising
- Bleeding problems
- Bleeding gums
- Frequent nosebleeds
- Enlarged lymph nodes

ALLERGY IMMUNOLOGY

- No complaints
- Hives
- Allergic Rash
- Allergy Symptoms
- Seasonal Allergies
- Food Intolerances
- Animal Intolerances
- Recurring/Frequent Infections

BREAST

- No complaints
- Breast lump L or R
- Breast pain
- Breast tenderness
- Breast redness
- Nipple discharge
- Bloody nipple discharge
- Breast enlargement

ANY OTHER HEALTH CONCERNS:
