Family Care Network
We Take Care

13-18 ADOLESCENT MEDICAL HISTORY

Name _____ Date of Birth _____ Today's Date _____

Parent name _____ Parent name_____

MEDICATIONS

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

_____

_____

_____

ALLERGIES

Medications you are allergic to or have reactions to: _____

_____

List any non-medication allergies: _____

IMMUNIZATIONS

Please bring copy of child's immunization record to the visit, or indicate where immunization records are maintained. _____

TESTS/EXAMS

Check and indicate date

❑ Physical or Sports exam Date:_____ ❑ Eye exam Date:_____

❑ Well Exam Date:_____ ❑ Other: _____ Date: _____

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

PERSONAL MEDICAL HISTORY

Check 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

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): _____

_____

_____

SURGERIES

Check if you have had: ❑ Tonsillectomy ❑ Adenoidectomy ❑ Appendectomy

List any other surgeries:

Type _____ Date_____ Type_____ Date_____

Type _____ Date_____ Type_____ Date_____

Type _____ Date_____ Type_____ Date_____

HOSPITALIZATIONS (Other than for surgery)

Please list:

Date _____ Reason_____

Date _____ Reason_____

Date _____ Reason_____

Date _____ Reason_____

FAMILY HISTORY

Relationship	Name	Birth Year	Age At Death	Cause Of Death
Father				
Mother				
Brothers & Sisters				
Children				

Name _____ Date of Birth _____

FAMILY HISTORY

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

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

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

Other significant family history: _____

SOCIAL HISTORY

School_____ Grade_____

Parent Occupation _____ Parent Occupation_____

Are you adopted? ❑ Yes ❑ No

Name and date of birth for each person *living in your household*, and their relationship to you _____

_____

Life changes (new siblings, divorce, or 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

RISK FACTORS

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

How many caffeinated drinks each day?_____ How much juice/soda each day?_____

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

Are there any guns in the home? ❑ Yes ❑ No

Have you had any dental care within the last 6 months? ❑ Yes ❑ No

Sun exposure: ❑ Frequently ❑ Occasionally ❑ Rarely ❑ Remote Uses sunscreen: ❑ Yes ❑ No

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

Do you smoke? ❑ Current ❑ Quit ❑ Never If quit, when_____ Passive smoke exposure: ❑ Yes ❑ No

Do you use any other tobacco products? ❑ Yes ❑ No If yes, please list_____

Do you use marijuana? ❑ 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 hours of screen time each day? _____

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
- Loss of appetite
- 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:

_____

_____

_____

_____

_____

_____

_____