Adolescent History Form--- Ages 12-17

Name: ________________________________ Age: _____ DOB: ___________ Date: ________________

Current Medications: (List all medications you are currently taking including birth control, vitamins, herbal medicine, weight loss drugs)____

____

Allergies: ____**Date of last Tetanus Shot?** _____________

Hospitalizations/Surgeries: ____

Do you smoke? _____Yes ________No How much? _______________________________________

Do you use street drugs, steroids, or inhalants? ___Yes ___No Which kinds? _____________How often?_____

Do you ever drink alcoholic beverages? ___Yes ___No How often? _________________How much?________

Last Dental Visit? __________________________ Having Dental Problems? _____ Yes ______ No

Have you or your parents, grandparents, brothers or sisters ever had?

1. High Blood Pressure □ Self □ Family; Who? ______________________________
2. Diabetes □ Self □ Family; Who? ______________________________
3. Thyroid Disease □ Self □ Family; Who? ______________________________
4. Severe Headaches □ Self □ Family; Who? ______________________________
5. Cancer □ Self □ Family; Who? ______________________________
6. Serious Depression □ Self □ Family; Who? ______________________________
7. Anemia/Sickle Cell Anemia □ Self □ Family; Who? ______________________________
8. Eating Disorder □ Self □ Family; Who? ______________________________
9. Chest Pain □ Self □ Family; Who? ______________________________
10. Heart Problems □ Self □ Family; Who? ______________________________
11. Sudden death before age 50 □ Family; Who? ______________________________
12. Asthma □ Self □ Family; Who? ______________________________
13. Stroke □ Self □ Family; Who? ______________________________
14. Epilepsy □ Self □ Family; Who? ______________________________
15. Bleeding Disorder □ Self □ Family; Who? ______________________________
16. Chicken Pox □ Self

How would you rate your activity level (active walking or sports)?

_______ 5-7x per week _________ 3-4x per week _______1-2x per week

Do you think something is wrong with your body development or the way you look?

________ Yes ___________No

Are you having difficulties at home with family and/or friends?

________Yes ___________ No

Have you ever been physically, emotionally, or sexually abused?

________Yes ___________ No

Nutritional Screening

Please check all that apply

___ No Problem ___Diabetic

____ Not eating ___Nausea

____ Taking liquids only

____ Trouble chewing

____ Trouble swallowing

____ History of eating disorder

____ Special Diet

____ Other:_________________

Females only:

At what age did you have your first menstrual period? _________

Are you having problems with your periods? □ Yes □ No

Do you do monthly self breast exams? □ Yes □ No

Do you think you might be pregnant? □ Yes □ No

Have you ever been pregnant? □ Yes □ No

Have you ever had an abnormal pap smear? □ Yes □ No When? ________________

Have you ever had sex? □ Yes □ No

Do you use or want to use birth control? Currently using: _________________ Want to use: _____________

Males only:

Do you do monthly self testicular exams? □ Yes □ No

Have you ever had sex? □ Yes □ No

_______________________________ _______________ ___________________

Patient / Parent or Guardian Signature Relationship Date

_______________________________ _______________

Provider Signature Date