

**Adolescent Health History Form  
11 - 20 years of age**

Name	<input type="checkbox"/> M <input type="checkbox"/> F	DOB	Today's Date
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**PAST MEDICAL HISTORY:**

**Major Medical Problems:**  No  Yes, (list, with dates) \_\_\_\_\_

**Hospitalizations/Operations:**  No  Yes, (list, with dates) \_\_\_\_\_

**Broken bones/Severe Injuries:**  No  Yes, (list, with dates) \_\_\_\_\_

**ALLERGIES/REACTIONS to food, medicines or vaccinations:**

**CURRENT MEDICATIONS (name, strength, frequency):**

**NUTRITION HISTORY:**

Any unusual feeding/dietary problems?  No  Yes If yes, explain \_\_\_\_\_  
 How many servings of fruit do you/your child eat a day? \_\_\_\_\_ Vegetables? \_\_\_\_\_ Meat? \_\_\_\_\_ Dairy? \_\_\_\_\_  
 Do you/your child drink soda/pop?  No  Yes If yes, how much per day? \_\_\_\_\_  
 Do you/your child drink water?  No  Yes If yes, how much per day? \_\_\_\_\_  
 Are you/your child a good eater?  No  Yes  
 Do you/your child eat junk food frequently?  No  Yes

**DEVELOPMENT/BEHAVIORAL HISTORY:**

Any problems sleeping at night?  No  Yes If yes, explain \_\_\_\_\_  
 Hours of sleep per night? \_\_\_\_\_  
 Current grade in school \_\_\_\_\_ Any concerns about school performance? \_\_\_\_\_  
 Any concerns about relationship with:  
 Teachers  No  Yes Peers  No  Yes If yes, explain \_\_\_\_\_  
 School grades: \_\_\_\_\_ Best friend?  No  Yes Many friends?  No  Yes Dating?  No  Yes  
 Sexually active?  No  Yes Using birth control?  No  Yes Age of first period (females only)? \_\_\_\_\_  
 Would you like more information about birth control?  No  Yes  
 Involved in activities/sports/exercise?  No  Yes (list) \_\_\_\_\_

**IMMUNIZATIONS:**

Hepatitis B \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ Tdap \_\_\_\_\_ Polio \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
 MMR \_\_\_\_\_, \_\_\_\_\_ Varicella \_\_\_\_\_, \_\_\_\_\_ or Chickenpox disease (date) \_\_\_\_\_  
 Hepatitis A \_\_\_\_\_, \_\_\_\_\_ Influenza \_\_\_\_\_ HPV \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ Meningococcal \_\_\_\_\_

**DENTAL HISTORY:**

Have you/your child been seen by a dentist?  No  Yes If yes, how often? \_\_\_\_\_

Date of last visit? \_\_\_\_\_

**VISION HISTORY:**

Have you/your child had a vision screening done?  No  Yes If yes, when? \_\_\_\_\_

Do you/your child wear glasses?  No  Yes

**FAMILY HISTORY:** Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions, if deceased due to a condition please put age at death:

Heart Disease \_\_\_\_\_ High Blood Pressure \_\_\_\_\_

High Cholesterol \_\_\_\_\_ Stroke \_\_\_\_\_

Cancer, specify type \_\_\_\_\_ Genetic Disorders \_\_\_\_\_

Diabetes \_\_\_\_\_ Asthma/COPD \_\_\_\_\_

Anemia \_\_\_\_\_ Alcoholism/Drug overdose \_\_\_\_\_

Other: \_\_\_\_\_

**SOCIAL HISTORY:**

**Who lives at home?**

Name	Age	Relationship	Name	Age	Relationship
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Are you/the child's parents  Married  Unmarried  Divorced  Separated

Child care situation  Parents  Other (specify who and how often) \_\_\_\_\_

Is violence/abuse at home a concern?  No  Yes

**Safety:**

Do you/your child use a helmet and protective gear for bike riding, skateboarding, skating, etc?  No  Yes

Use of seat belts consistently?  No  Yes

Do you have firearms at home?  No  Yes

Does your house have a working smoke detector?  No  Yes

**Exposure/Habits:**

Any concerns about lead exposure?  No  Yes

Do any household members smoke?  No  Yes

TV – hours per day watched \_\_\_\_\_

Computer – hours per day used \_\_\_\_\_

Video games – hours per day played \_\_\_\_\_

**Other Concerns:**

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

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Physical development       | <input type="checkbox"/> Emotional development          | <input type="checkbox"/> Weight                               |
| <input type="checkbox"/> Diet/Nutrition             | <input type="checkbox"/> Amount of physical activity    | <input type="checkbox"/> Relationship with parents/family     |
| <input type="checkbox"/> Self image                 | <input type="checkbox"/> Excessive moodiness            | <input type="checkbox"/> Depression                           |
| <input type="checkbox"/> Lying, stealing, vandalism | <input type="checkbox"/> School grades/absences         | <input type="checkbox"/> Drug use                             |
| <input type="checkbox"/> Smoking/chewing tobacco    | <input type="checkbox"/> Alcohol use                    | <input type="checkbox"/> Sexual behavior                      |
| <input type="checkbox"/> Pregnancy risk             | <input type="checkbox"/> Violence, gangs, guns, weapons | <input type="checkbox"/> Sexually Transmitted Diseases (STDs) |

Signature of person completing this form: \_\_\_\_\_ Relationship: \_\_\_\_\_

Reviewed by \_\_\_\_\_ Date \_\_\_\_\_