MyCare Health Center

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www.mycarehealthcenter.org

ADOLESCENT HEALTH HISTORY

(Use for ages 8 to 16)

Today's Date:

Patient Name: Date of Birth: Age:

Pharmacy (Name and location):

PAST MEDICAL HISTORY Previous Doctor:

Allergies/reactions to medicines or vaccines:

Current Medications: (including vitamins, herbs, supplements, birth control pills)

Name	Dose	How many times per day	When started

Major Medical Problems: None Yes (list)

Hospitalizations/Operations: None Yes (list)

Broken bones/Severe Injuries: None Yes (list)

REVIEW OF SYSTEMS Please check (✓) any current problems your child has on the list below:

General
- fever/chills/excessive sweating
- unexplained weight loss/gain

Eyes
- squinting/cross-eyed

Ears/Nose/Throat
- usually loud voice/hard of hearing
- mouth breathing/snoring
- bad breath
- frequent runny nose
- problems with teeth/gums

Heart/Cardiovascular
- tires easily with exercise
- shortness of breath
- fainting
- chest pain with exercise

Lungs/Respiratory
- cough/wheeze
- chest pain

Gastrointestinal
- nausea/vomiting/diarrhea
- constipation
- blood in bowel movement

Genitourinary
- bedwetting
- pain with urination
- discharge: penis or vagina

Musculoskeletal
- muscle/joint pain

Skin
- rashes
- unusual moles

Allergy
- hay fever/itchy eyes

Neurological
- headaches
- weakness
- clumsiness
- speech problems

Psychiatric/Emotional
- anxiety/stress
- problems with sleep
- depression
- nail biting/thumb sucking
- bad temper/jealousy

Blood/Lymph
- unexplained lumps
- easy bruising/bleeding

SOCIAL/SCHOOL HISTORY Current grade: Name of School

Concerns about school performance? No Yes

Concerns about relationship with teachers? No Yes Students? No Yes

School grades: Best Friend? No Yes Many friends? No Yes Dating? No Yes

Sexually active? No Yes Using birth control? No Yes Would like more information? No Yes

Females: Have you started your period? No Yes Last Menstrual Period

Involved in activities/sports/exercise? No Yes (list)

ADOLESCENT HEALTH HISTORY

Patient's Name: Today's Date:

FAMILY HISTORY **Please indicate family members (mother, father, sister, brother, aunt, uncle, grand parent)**

Alcoholism Heart Attack High Cholesterol Stroke

Cancer High Blood Pressure Depression/Suicide Diabetes

In the past year, have there been any changes in your family? (check all that apply)

Marriage Separation Divorce Move to new neighborhood Change to new school

Serious Illness Loss of job Death Birth Other changes

Who lives at home with you?

Name	Age	Relationship

IMMUNIZATIONS/INFECTIOUS DISEASE **Did you bring your child's immunization record with you today?**

Yes No Will bring to next appointment Records with another care provider(Name)

Has your child had: Chicken Pox Measles Mumps Rubella Tuberculosis (TB)

Hepatitis B Meningitis Penumonia Influenza (flu) Other Disease

PREVENTION/SAFETY

What is your dentist's name? Date of last dental exam:

Do you or does anyone in your home:

Use tobacco products? No Me Household Member Type: Amount:

Drink alcohol? No Me Household Member Type: Amount:

Use Illegal Drugs No Me Household Member Type: Amount

Does your home have smoke detectors? No Yes

Do you have a gun in your house? No Yes If yes, is it unloaded and out of reach? No Yes

Do you regularly use:

Helmets for bikes/boards/ATVs/motorcycles? No Yes

Seat belts when riding or driving a car? No Yes

OTHER CONCERNS **Please review this list and check any concerns you have about the patient:**

Physical development Emotional development Sleep patterns

Weight Diet/Nutrition Amount of physical activity

Relationship with parents and family Choice of friends Self image/self worth

Excessive moodiness or rebellion Depression Lying, stealing, vandalism

Violence/gangs/guns/weapons School grades/absences Drug use

Smoking/chewing tobacco Alcohol use Sexual behavior

Sexual orientation (heterosexual, gay) Pregnancy risk Sexually transmitted disease

What is your greatest challenge for you/your child?

What about you/your adolescent makes you proud?

Is there anything you would like to discuss in private today?

Signature of person completing this form:

Relationship to patient: