ADOLESCENT HEALTH HISTORY (AGE 12-20)

-All information will be kept confidential -

HEALTH HISTORY: **Language you want to be serve at our clinic: ☐ English ☐ Spanish ☐ Other_____**

Do You have or have you ever had any of the following?

	YES	NO
EYE		
Trouble seeing (circle): Right Left Both	☐	☐
Blurred vision unless corrected by glasses	☐	☐
EAR		
Frequent ear infections	☐	☐
Hearing problems (circle): Right Left Both	☐	☐
NOSE		
Frequent colds or throat infections	☐	☐
Stuffy nose or constant runny nose (hayfever)	☐	☐
MOUTH		
Dental problems	☐	☐
Tonsil infections	☐	☐
CARDIO-RESPIRATORY		
Heart disease/problem	☐	☐
High blood pressure	☐	☐
High cholesterol/triglycerides	☐	☐
Anemia/Sickle Cell disease or trait	☐	☐
Pneumonia	☐	☐
Wheezing or asthma	☐	☐
Asthma/lung disease	☐	☐
Tonsils and adenoids removed	☐	☐
Tuberculosis/positive skin test	☐	☐
DIGESTIVE		
Vomiting.....	☐	☐
Stomach aches	☐	☐
Constipation/diarrhea	☐	☐
Use of laxatives	☐	☐
GENITO-URINARY		
Occassionally wetting the bed	☐	☐
Trouble with urination	☐	☐
Kidney disease/problems	☐	☐
Frequent bladder infections	☐	☐
LOCOMOTOR		
Serious accident	☐	☐
Broken bones	☐	☐
Leg paints/joint pains	☐	☐
NERVOUS SYSTEM		
Headaches (frequent)	☐	☐
Epilepsy (convulsions)	☐	☐

	YES	NO
NERVOUS SYSTEM (continued)		
Blackouts of dizzy spells	☐	☐
Head injury/brain tumor	☐	☐
"Passed out" or "knocked out" (concussion)	☐	☐
Eczema or hives	☐	☐
Measles: Rubella (3-day)	☐	☐
Rubeola (10-day)	☐	☐
Had MMR immunization _____ Date	☐	☐
PSYCHO-SOCIAL		
Depression/mentally unstable	☐	☐
Alcoholism/drug addiction	☐	☐
Marked weight change (gain or loss)	☐	☐
GENERAL MEDICAL		
Breast lumps/discharge	☐	☐
Liver – hepatitis, mononucleosis	☐	☐
Recent jaundice (yellow skin color)	☐	☐
Gallbladder problems (pain in upper right side)	☐	☐
Thyroid problems	☐	☐
Diabetes	☐	☐
Trouble falling asleep	☐	☐
Awake during the night	☐	☐
Very tired during the day	☐	☐
Cancer – Where?_____	☐	☐
_____		
Operations – for what? _____	☐	☐
_____		
Hospitalizations – for what? _____	☐	☐
_____		
Allergies: to medication (list what) _____	☐	☐
_____		
_____		
Allergies: to food (list what) _____	☐	☐
_____		
_____		
Allergies: to other (list what) _____	☐	☐
_____		
_____		

FAMILY HISTORY [Mother (M), Father (F), Sister (S), Brother (B), Grandmother (GM), Grandfather (GF), Aunt (A), Uncle (U)]

Who in your family has had trouble with the following?

Heart disease	_____	Sickle Cell Disease	_____
High blood pressure	_____	Tay Sachs disease	_____
Diabetes	_____	Congenital deformities	_____
Cancer	_____	Mental illness	_____
Kidney disease	_____	Alcoholism	_____
Stroke	_____	Addictive behavior	_____
Epilepsy/convulsion disorder	_____	Other	_____

Please TURN OVER to complete History →

Date _____ History form reviewed by _____

Patient's D.O.B. _____ **Patient's Name (Last, First)** _____

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SEXUAL HISTORY:

this information will <u>not</u> be shared with others

FEMALE	YES	NO
Concern that my breasts are too small or too big ……	☐	☐
Vaginal infections (circle):		
Gonorrhea Chlamydia Syphilis		
Herpes Vaginal Warts Yeast		
Painful menstrual cramping ……	☐	☐
Abnormal/bad Pap Smear ……	☐	☐
Worried that I might become pregnant ……	☐	☐
Worried that I might not be able to get pregnant ……	☐	☐

MALE	YES	NO
Concern that my penis is too small ……	☐	☐
Penile discharge or burning on urination ……	☐	☐
Worried that I might have Herpes ……	☐	☐
Worried that I might have genital warts ……	☐	☐
Worried that I might make someone pregnant ……	☐	☐
BOTH (FEMALE & MALE)		
Not yet ready for sex, but feel pressured ……	☐	☐
Sexually active with one person ……	☐	☐
Sexually active with more than one person ……	☐	☐
Tested for HIV – AIDS ……	☐	☐

SPORT EVALUATION	YES	NO
Are you presently taking any medication or pills? ……	☐	☐
Have you ever passed out during or after exercise? ……	☐	☐
Have you ever been dizzy during or after exercise? ……	☐	☐
Have you ever had chest pain during or after exercise?	☐	☐
Do you get tired more quickly than your friends during exercise? ……	☐	☐
Have you ever had high blood pressure? ……	☐	☐
Have you ever been told that you have a heart murmur?	☐	☐
Have you ever had racing of your heart or skipped heartbeats? ……	☐	☐
Do you have any skin problems (itching, rashes, acne)?	☐	☐
Have you ever had a head injury? ……	☐	☐
Have you ever been knocked out or unconscious? ……	☐	☐
Have you ever had a seizure? ……	☐	☐
Have you ever had a stinger, burner or pinched nerve?	☐	☐
Have you ever had heat or muscle cramps? ……	☐	☐
Have you ever been dizzy or passed out in the heat? ….	☐	☐
Do you have trouble breathing or do you cough during or after activity? ……	☐	☐
Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)? ……	☐	☐

	YES	NO
Have you had any problems with your eyes or vision? ….	☐	☐
Do you wear glasses or contacts or protective eye wear? ……	☐	☐
Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints? ……	☐	☐

☐ Head ☐ Shoulder ☐ Thigh ☐ Neck
☐ Elbow ☐ Knee ☐ Chest ☐ Forearm
☐ Shin/Calf ☐ Back ☐ Wrist ☐ Ankle
☐ Hip ☐ Hand ☐ Foot

Have you had any other medical problems? (infectious mononucleosis, diabetes, etc)? ……	☐	☐
Have you had a medical problem or injury since your last evaluation? ……	☐	☐

When was your last tetanus shot? _____

When was your last measles immunization? _____

When was your first menstrual period? _____

When was your last menstrual period? _____

What was the longest time between your periods last year?

_____

Below is a list of common problems reported to us by other teenagers. Check "YES" or "NO" for each so that we can better assist you.

	YES	NO
Worried about my heath ……	☐	☐
Follow a special diet ……	☐	☐
Concern about being too short or too tall ……	☐	☐
Concern about being too thin or too fat ……	☐	☐
Concern about myself, a friend or a family member being physically/sexually abused ……	☐	☐
Concern about myself, a friend or a family member drinking or using drugs ……	☐	☐
Worried about my parents' relationship ……	☐	☐
Would like to change my relationship with my parents..	☐	☐
Have a friend I can talk to about anything ……	☐	☐
Have trouble getting to school ……	☐	☐
Worried about school ……	☐	☐
Trouble about my future plants ……	☐	☐

	YES	NO
Feel so bad that I think about dying ……	☐	☐
Do you have other personal problems that you would like to discuss, but would rather not write down? ……	☐	☐
Do you wear a seat belt? ……	☐	☐
Do you exercise? ……	☐	☐
What kind? _____		
How often? _____		
Do you use appropriate safety equipment when you participate in recreational activities? ……	☐	☐
Are you interested in birth control/contraceptive information? ……	☐	☐
Are you interested in information on AIDS and/or other sexually transmitted diseases ……	☐	☐

SOCIAL HISTORY:

Ethnicity: ☐ Hispanic/Latino ☐Not Hispanic/Latino

Race: ☐Asian ☐Native Hawaiian ☐Other Pacific Islander ☐Other ☐American Indian ☐White ☐African Amer. ☐More than 1 Race

Tobacco or Cigarette Use: ☐ Yes ☐ No

If yes, how much: _____per day _____per week

HOUSEHOULD INFORMATION: (if applicable)	**N/A**
How many people is in your household? _____	☐
How much do you make monthly? _____	☐
What is the household income? _____	☐
What is your source of income? _____	☐