New Adolescent Patient History (11-19 years)

Today's Date:_____ Patient Name:_____ Date of Birth:_____
Last First Middle

Medical History

Have you ever stayed overnight in the hospital? ☐Yes ☐No

If yes, when and for what problem? _____

Have you ever had an operation? ☐Yes ☐No

If yes, what was it and when? _____

Do you take any medications? ☐Yes ☐No

If yes, what and for how long? _____

If you have ever had any of the following problems, please circle the problem and write how old you were when it started or when you had it:

Diagnosis / Condition	Age	Diagnosis / Condition	Age
Acne		Recurring headaches	
Asthma		Any heart problem or heart murmur	
Bladder infection		Learning problems	
Broken bones		Mononucleosis	
Chicken pox		Recurring stomach pain	
Concussion		Seizures	
Depression		Scoliosis / back trouble	
Emotional problems		Sprained ankle	
Hearing problems		Trouble seeing	

Health Concerns Today

Please check below if you have questions or concerns about any of these:

- ☐ Height
- ☐ Blood Pressure
- ☐ Acne
- ☐ Breasts
- ☐ Heart
- ☐ Weight
- ☐ Stomach pains
- ☐ Diarrhea
- ☐ Hearing problems
- ☐ Chest pain
- ☐ Coughing / Wheezing
- ☐ Wetting the bed
- ☐ Urination
- ☐ Headaches
- ☐ Trouble sleeping
- ☐ Tiredness
- ☐ Trouble seeing
- ☐ Learning problems
- ☐ School problems
- ☐ Joint pain
- ☐ Cancer
- ☐ Dying
- ☐ Menstruation
- ☐ Constipation
- ☐ Sexual concerns
- ☐ Physical/ sexual abuse
- ☐ Other:

Please return completed form to the appropriate physician's office.

New Adolescent Patient History (11-19 years), cont'd.

Today's Date:_____ Patient Name:_____ Date of Birth:_____
Last First Middle

Family Health Information

Please circle the disease if anyone in your family (parents, grandparents, brother/sister, aunts, uncles, or cousins) has these diseases and write your relationship to that person:

Disease	Relationship	Disease	Relationship
Alcohol abuse		High blood pressure	
Asthma		Kidney disease	
Cancer		Learning problems	
High cholesterol		Mental illness, suicide, trouble with nerves	
Deafness		Seizures	
Adult onset diabetes		Stroke	
Childhood onset diabetes		Sudden unexplained death	
Drug abuse		Thyroid disease	
Heart attack (less than 65yrs old)		Other diseases	

Family Information

With whom do you live? (Mom, Dad, brothers and sisters, other people?)
If split custody, please describe the arrangement.

_____

Have you had any family problems?

_____

Does anyone in your household smoke?

_____

Patient Signature:_____ Date:_____

If someone other than the patient completed this form, please give name & relationship: _____
Name Relationship

Nurse Name:_____ Signature:_____ Date Reviewed:_____

Please return completed form to the appropriate physician's office.