

$Medical\ History\ ({\tt Adult}\ {\tt 19}\ {\tt years\ old+})$

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$Medical\ History\ ({\tt Pediatric}\ {\tt Record}\ {\tt 0-12}\ {\tt years}\ {\tt old})$

Patient's Name		_ 🗆 🗆 Maie 🗆 Fernale 🛮 Ag]E
Parent or Guardian's Name			
Date of Birth	Daylime Phone No.		
HISTORY OF PRESENTICENESS			
	CAUDOMINENTAL LICTORY		•
	D Agartment	☐ Own room .	· Water/Sewage
	☐ Private home	Share foom with	
	. Bedrooms		Seplic tank
PAST MEDICAL HISTORY:	☐ Smokers	Persons living in house:	☐ Farm water
☐ No previous hospitalization ☐ No m	najor illness 🔲 Pets		
Other	Smcke Detectors		a Tallata yanna dal
SIRTHERATAL COLUMNIA SERVICE S	FAMEY HISTORY	RECORD OF HELINES	59加强制造机
Age of Mom Gravida/Para	Mother	Allergies	· .
Prenatal Care: 1 Yes (>8 visits) 1 No	Father	Chicken pox	
Complications duting pregnancy	Broihers/Siaters;	Pneumonia	
	1,ASSSITPSSS	T&A	
☐ Full term ☐ Premature wks	2	Tonsillitis	
Type of delivery:	S. ASR SEC HEIN	Major operations and/or	ໂຕຢູ່ນຕໍ່ຂອງ
☐ Normal Delivery	fl. Ana Sax Hamb		
C-Section due to	5. <u>Ags</u> Soc <u>Paris</u>		
Birth weight		Home Meds:	
Birth hospitel	Family Medical History:		
Complications after delivery	Cancer		Inemavem
The second secon	☐ Heart disease	Good hearing	
SEEDING DATA TELESIAN TELEVISIAN	Oiabetes	Good vision	
☐ Breast reeding mlns.	☐ Anemia	1 01	
Everyhrs.	☐ Sickle Cell	1 -	
☐ Formula: Type	☐ Mentel illness	1 1 A C 4 - 1 1 1 A 1 1 - 1 - 1 1 A 1 A 1 A 1 A 1	INIZATIONS :
Amount per feeding	☐ High blood pressure		
Everyhrs.	☐ Asthma		2
C Regular Diet	☐ Seizures	- 1 0	3
☐ Special Diet	☐ Bad nerves	4	4
☐ Good appelite	☐ Bad nerves	- 5 H	19 1
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Medical History (Adolescent Record 13-18 years old)

"表现的可有了自己和国心的配品的人。" Please help us help you by carefully filling in the attached medical form. All information you share with us will be kept strictly between you and your medical practitioners. FPAST MEDICAL HISTORY: (check Yes or No) Have you ever had: Are you currently taking medicines for any Reason? — Yes 🖸 No Yes 🗆 No An operation ----To stay over night in a hospital ----- Yes \(\sigma\) No If so, what is/are the name(s) of the medicines you take? An allergy to food _____ \quad Yes \quad No An allergy to medicine (e.g., penicillin) ------ Q Yes Q No. All allergy to other substances _____ \(\square\) Yes \(\square\) No Chickenpox ----- D Yes D No Rheumatic fever — Yes 🗆 No When was your last booster shot(s)?_____ Diabetes mellitus — □ Yes □ No □ Yes □ No " Sickle cell anemia ----Epilepsy (seizures) ———— Yes 🗆 No Pneumonia -----☐ Yes ☐ No FAIVILY HISTORY FOR FAIR FAIR Where were you born? Does anyone in your family have: Diabetes ---- □ Yes □ No High blood pressure ----- ☐ Yes ☐ No Do you live with yours (check all relatives you live with): ☐ Mother ☐ Brother (#) Asthma — Q Yes Q No □ Sister (#____) Heart attack or stroke —————————————————□ Yes □ No ☐ Stepmother TB (tuberculosis) — ☐ Yes ☐ No ☐ Father ☐ Niece (#______) Cancer ----- - Yes - No ☐ Stepfather □ Nephew (# ☐ Foster parent(s) ☐ Aunt(s)-☐ Grandmother ☐ Uncle(s) Alcohol Abuse ---- □ Yes □ No ☐ Grandfather ☐ Cousin(s) Drug use ---- ☐ Yes ☐ No ☐ Others ____ How long have you there: ☐ Always ☐ Months ___ ☐ Years What grade are you in: What are your plans for the future? Are you failing any subject? ---- Yes \(\sigma\) No If so, what? Have you ever been left back? ---- □ Yes □ No Have you ever been in special ed? _____ \(\text{Yes} \) No

PHSC ADB (Revised 06/12/09)



Medical History Ctd. (Adolescent Record 13-18 years old)

Do you have (or have you ever had) problems with: Have you ever had sores or lumps around	
Too many headaches \(\text{Yes} \) \(\text{No} \) your penis or vagina? \(\text{Yes} \)	s Q No
Dizzy or fainting spells	S 2 140
Anemía or low blood count	s 🗆 No
Your eyes D Yes No Would you like information about AIDS and	.5 (140
Your teeth Yes No safer sex? Yes	s 🗆 No
High blood pressure Tyes No Have you ever thought about being tested	72 IAO
Your heart	es 🗆 No
Chest pains \(\text{Yes} \) \(\text{No} \)	
Trouble breathing \(\textstyle \) Yes \(\textstyle \) No \(\textstyle \) FEMALE: Have you had your first period? \(\textstyle \) Yes	es Q No
Stomach pains \(\text{Yes} \) \(\text{No} \) If no, go to next section.	55 CL 140
Vomiting ☐ Yes ☐ No At what age was your first period?	
Dlarrhea	
Constipation	
High or low blood sugar	22 CT 140
Urine Injections \(\sum \) Yes \(\sum \) No \(\text{Do you have pain (cramps) with your period? } \(\sum \) \(\sum \) Yes	es 🗆 No
Your kidney	es UNO
Frequent rashes or hives	
Acne	es 🗆 No
Swollen joints \ \textstyre \ \textsty	Du
Have you ever tried:	es 🗆 No
	П.,
you or have you ever been on a special diet? U Yes U No Marijuana (joint, reefer, chiba) U Yes U No Angel dust	
	-
10)	
you ever try to go a whole day without eating? Yes No Pills (ups, downs, etc.)	
Alcohol (beer, wine, hard liquor)	es 🗆 No
≥ve you ever had sex? ☐ Yes ☐ No Have you ever felt your substance abuse	
If you did have sex, at what age did you have sex is a problem?	es 🗆 No
for the first time?	
ο you ever feel attracted to someone of the Do you feel depressed (down) a lot?	es 🗆 No
same sex?	
ave you had sex with? Have you ever thought about killing/hurting	
One partner	
☐ Opposite Sex ☐ Same sex If yes, have you ever tried? — ☐ Y	es 🗆 No
ave you or your partner ever used any birth Have you ever had counselling with a social	
control methods (condoms, withdrawal or worker or other counselor?	
Pulling out, pills, etc.)? Yes No Are you having problems at home? Yes	
If yes, which one(s)? Has anyone ever hit you very hard or beat you? \[\sqrt{Y}	es 🗆 No
ould you like to speak to someone about Has anyone ever touched your body in a way	
hirth control methods? Yes No that made you uncomfortable or was	
ave you ever had a sexually transmitted disease/ without your consent?	es 🗆 No
VD (such as gonorrhea, chlamydia, syphilis, Did anyone ever force you or try to force you	
herpes or chancrold)?	es 🗆 No
viewed by:	