Shah and Associates Family Practice _____

Name

Adolescent Medical History Form

PLEASE COMPLETE ALL **4** PAGES

Please answer the following questions. This form will NOT be put directly into your medical chart. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details. Your answers are kept confidential and are NOT shared without your consent. **Thank you!**

AGE _____ How would you rate your general health? ◯Excellent ◯Good ◯Fair ◯Poor

WHAT CONCERNS DO YOU HAVE ABOUT YOUR HEALTH OR BODY: _____

_____

PLEASE LIST ALL MEDICATIONS, VITAMINS, HERBS, AND SUPPLEMENTS YOU TAKE:

Medication Dose (e.g., mg/pill) How many times per day When started

_____

_____

_____

_____

ALLERGIES/REACTIONS TO MEDICINES or VACCINATIONS: _____

PREVENTATIVE CARE: When were your most recent:

Hepatitis A shot_____ Hepatitis B shot_____ Influenza (flu shot)_____ Measles shot_____

Pneumovax shot_____ Rubella shot_____ Tetanus (Td) shot_____

Varicella (chicken pox) shot or illness_____ PPD (Tuberculosis skin test)_____ Dental Exam_____

PERSONAL MEDICAL HISTORY: Please list any major medical problems and their dates.

_____

_____

Hospitalizations/operations (with dates): _____

Broken bones or severe injuries (with dates): _____

SOCIAL HISTORY: Who lives at home with you?

Name Age Relationship to you Occupation Highest Education Level

_____

_____

_____

_____

Are your parents ◯Married ◯Unmarried ◯Separated ◯Divorced **If divorced or separated, when?**_____

Do you have any pets at home? _____ If so, what kind and how many? _____

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

❑ Marriage	❑ Loss of job	❑ Birth
❑ Separation	❑ Move to new neighborhood	❑ Serious illness
❑ Divorce	❑ Change to new school	❑ Death
❑ Other changes/stresses		

SCHOOL HISTORY: Current grade _____ Name of school _____

Do you have any concerns about your performance in school? ___ Do your parents? ___ Do your teachers? ___

What do you want to do or be after you complete school? _____

EXERCISE: What sports or exercise do you do? _____ Days per wk? ___ Minutes each time? ___

How many minutes per day do you watch TV or use a computer? _____

INJURY PREVENTION:

Do you wear sunscreen when in the sun?	◯Yes ◯No
Are you frequently exposed to loud noises, such as concerts, earphones, or machinery?	◯Yes ◯No
Do you wear a seatbelt when riding in a car, truck, or van?	◯Yes ◯No
Do you wear a helmet when skateboarding, rollerblading, or riding a bicycle or scooter?	◯Yes ◯No
Do you ride a motorcycle, hang glide, or fly an airplane?	◯Yes ◯No
Does your home have smoke detectors?	◯Yes ◯No
Is there a gun in your home?	◯Yes ◯No
If so, is it kept unloaded and locked out of reach?	◯Yes ◯No
Do students in your school carry guns or knives to school?	◯Yes ◯No
Are you worried about violence or your safety?	◯Yes ◯No
Have you ever been in trouble with the police?	◯Yes ◯No

DIET:

Do you eat 5 servings of fruits and vegetables every day?	◯Yes ◯No
Do you drink 4 glasses of milk (1 quart) daily or get calcium from other sources?	◯Yes ◯No
Are you happy with your current weight?	◯Yes ◯No

Do you follow a special diet? ◯Yes ◯No If so, please describe: _____

Have you ever done any of the following to lose weight:
Skipped meals, taken pills or other medications, caused vomiting, or used laxatives? ◯Yes ◯No

Caffeine intake: ❑ None ❑ Coffee/tea ____ cups/day ❑ Soda ____ cans/day ❑ Chocolate ____ oz./day

SUBSTANCE USE:

Have you ever tried smoking cigarettes? ◯Yes ◯No If so, when was the last time? _____

Do you smoke cigarettes regularly ◯Yes ◯No If so, how many cigarettes each day? _____

At what age did you start? _____ Are you interested in quitting? ◯Yes ◯No

Have you ever tried beer, wine, or other liquor? ◯Yes ◯No When was the last time? _____

Do you drink alcohol regularly? ◯Yes ◯No If so, how often? _____

Have you ever been drunk? ◯Yes ◯No

Do you use any “street drugs” such as marijuana, ecstasy, and others? ◯Yes ◯No
If so, which ones? _____

Have you ever driven or been in a car with a driver under the influence of drugs or alcohol? ◯Yes ◯No

Are you worried about the alcohol or drug use of a friend or anyone who lives in your home? ◯Yes ◯No

Does anyone in your home smoke cigarettes? ◯Yes ◯No
If so, do they smoke in the house? ◯Yes ◯No

MOOD:

In the past few weeks, have you been depressed or extremely sad, with nothing to look forward to? ◯Yes ◯No

Have you ever had thoughts about harming yourself or committing suicide? ◯Yes ◯No

Would you like to get counseling about anything that is bothering you? ◯Yes ◯No

Have you ever been abused: physically, emotionally, or sexually? ◯Yes ◯No

RELATIONSHIPS:

Do you have a friend you really like and feel you can talk to? ◯Yes ◯No

Are you dating someone regularly? ◯Yes ◯No

Do you have any questions about sex, pregnancy, or sexually transmitted infections? ◯Yes ◯No

Would you like information about preventing pregnancy? ◯Yes ◯No

Would you like information about preventing sexually transmitted infections? ◯Yes ◯No

Would you like information about homosexuality, bisexuality, or being gay? ◯Yes ◯No

Have you ever had sexual intercourse? ◯Yes ◯No

Has anyone ever forced you to do something sexual against your will? ◯Yes ◯No

Do you need a birth control method now? ◯Yes ◯No

Would you like to be tested now for sexually transmitted infections? ◯Yes ◯No

REVIEW OF SYMPTOMS: Please check (✓) any CURRENT symptoms you have from the list below:

Constitutional / Endocrine
___ Fevers/chills/excessive sweating
___ Unexplained weight loss/gain
___ Feeling tired a lot

Eyes
___ Blurry vision

Ear / Nose / Throat
___ Trouble with hearing
___ Mouth breathing/snoring
___ Frequently runny nose
___ Problems with teeth/gums

Respiratory
___ Cough/wheeze

Gastrointestinal
___ Abdominal pain
___ Nausea/vomiting/diarrhea
___ Constipation

Genitourinary
___ Bedwetting
___ Discharge: penis or vagina
___ Pain with urination
___ Problems with periods (females)

Neurological
___ Headaches

Musculoskeletal
___ Muscle/joint pain or swelling

Allergy
___ Hay fever/itchy eyes
___ Frequent sneezing or stuffy nose

Cardiovascular
___ Tire easily with exertion
___ Shortness of breath
___ Palpitations (irregular heart beat)

Skin
___ Rashes or itching
___ Acne
___ Unusual moles

Psychiatric / Emotional
___ Speech problems
___ Anxiety/stress
___ Sleep problems/nightmares
___ Depression/feeling sad
___ Nail biting
___ Bad temper/angry outbursts/ feeling moody
___ Learning difficulties

Blood / Lymph
___ Unexplained lumps
___ Easy bruising/bleeding

Please indicate any other concerns you want to discuss today:

FAMILY HISTORY: Please indicate with a check (✓) relatives with any of the following conditions:

Medical Condition	Admin use only	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad
Alcoholism	33								
Asthma	5								
ADD (Attention Deficit Disorder)	80								
Bleeding Problems	7								
Cancer, Breast	8								
Cancer, Colon	35								
Cancer, Melanoma	10								
Cancer, Ovary	11								
Cancer, Prostate	12								
Heart Attack/Heart Disease	13								
Depression	14								
Diabetes, on insulin shots	37								
Diabetes, not on insulin	38								
High cholesterol	22								
High blood pressure	23								
Learning disability	74								
Migraine headaches	71								
Psychiatric problem	75								
Scoliosis	76								
Seizures	27								
Stroke	28								
Substance abuse	43								
Sudden death	77								
Thyroid disorders	30								
Other:									
Other:									