

**PARTNERSHIP HEALTH CENTER  
ADOLESCENT MEDICAL HISTORY FORM**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**PAST HEALTH PROBLEMS**

Please indicate if you have experienced any of the following health problems.

<b><u>Illness</u></b>	<b><u>Yes</u></b>	<b><u>No</u></b>	<b><u>Illness</u></b>	<b><u>Yes</u></b>	<b><u>No</u></b>	<b><u>Illness</u></b>	<b><u>Yes</u></b>	<b><u>No</u></b>
<b><u>Eyes:</u></b> Blurry vision	_____	_____	<b><u>Skin</u></b>	_____	_____	Asthma	_____	_____
<b><u>Ears/Nose/Throat</u></b>			Rashes or itching	_____	_____	High cholesterol	_____	_____
Trouble with hearing	_____	_____	Acne	_____	_____	Hepatitis	_____	_____
Ear trouble or pain	_____	_____	Unusual moles	_____	_____	Head injury	_____	_____
Mouth breathing/snoring	_____	_____	<b><u>Genitourinary</u></b>			Convulsions/seizures	_____	_____
Frequent runny nose	_____	_____	Bedwetting	_____	_____	Cancer/tumor	_____	_____
Problems with teeth/gums	_____	_____	Discharge from penis or vagina	_____	_____	Anemia	_____	_____
Hay fever/itchy eyes	_____	_____	Pain with urination	_____	_____	Diabetes	_____	_____
Frequent sneezing or stuffy nose	_____	_____	Problems with periods (females)	_____	_____	Dental problems	_____	_____
<b><u>Lungs</u></b>			Bowel Problems	_____	_____	Speech problems	_____	_____
Cough/wheeze	_____	_____	Kidney or bladder problems	_____	_____	Anxiety/stress	_____	_____
Bronchitis frequent	_____	_____	<b><u>Misc. Symptoms</u></b>			Sleep problems/nightmares	_____	_____
<b><u>Stomach</u></b>			Fevers/chills/excessive sweating	_____	_____	Depression/feeling sad	_____	_____
Abdominal Pain	_____	_____	Unexplained weight loss/gain	_____	_____	Nail biting	_____	_____
Nausea/vomiting/diarrhea	_____	_____	Feeling tired a lot	_____	_____	Bad temper/angry outburst	_____	_____
Constipation	_____	_____	Headaches/migraines	_____	_____	Feeling moody	_____	_____
Ulcer	_____	_____	Muscle/joint pain or swelling	_____	_____	Learning difficulties	_____	_____
<b><u>Heart</u></b>			Unexplained lumps	_____	_____	Other _____	_____	_____
Tire easily with exertion	_____	_____	Easily bruising/bleeding	_____	_____	_____	_____	_____
Shortness of breath	_____	_____	Thyroid problems	_____	_____	_____	_____	_____
Irregular heart beat	_____	_____	Pneumonia	_____	_____	_____	_____	_____
Heart murmur	_____	_____	Hay Fever	_____	_____	_____	_____	_____

AGE: \_\_\_\_\_ How would you rate your general health?  Excellent  Good  Fair  Poor

What concerns do you have about your health or body? \_\_\_\_\_

**MEDICATIONS:** \_\_\_\_\_

**MEDICATION ALLERGIES:** \_\_\_\_\_

<b>HOSPITALIZATIONS:</b>	
Reason	Hospital and City

<b>INJURIES:</b>	
Reason	Hospital and City

**SOCIAL HISTORY:** Who lives at home with you?

Name	Age	Relationship to you	Occupation

Are your parents  Married  Unmarried  Separated  Divorced If divorced or separated, when? \_\_\_\_\_

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

- Marriage  Divorce  Move to new neighborhood  Birth  Death  
 Separation  Loss of job  Change to new school  Serious illness  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? \_\_\_\_\_ Min. 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

Is there a gun in your home?  Yes  No

If so is it kept unloaded and locked out of reach?  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: \_\_\_\_\_  Yes  No

Have you ever done any of the following to lose weight: \_\_\_\_\_  Yes  No

Skipped meals, taken pills or other medications, caused vomiting, or used laxatives?

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? \_\_\_\_\_

### 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 homosexuality or 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