

ADOLESCENT/TEEN HEALTH HISTORY (10-18 YEARS)

Name: _____ Date: _____ DOB: _____ Age: _____

Condition (Do you have or have you ever had any of the following?)	Y	N	Date of Onset	Family History	Person: (Mother, Father, Grandmother, Grandfather, Brother, Sister, Etc.)
Acid Reflux/Heartburn				Adopted <input type="checkbox"/>	
Acne				Asthma	
ADD or ADHD				Cancer _____	
Anemia				Cancer _____	
Arthritis				Diabetes	
Asthma				Heart Disease	
Bleeding/Clotting Disorder				High Blood Pressure	
Blood Clots/DVT				High Cholesterol	
Cancer – Type _____				Kidney Disease	
Chronic Constipation				Seasonal Allergies	
Depression				Other:	
Diabetes Type I or II					
Eating Disorder					
Eczema					
Ear Infections (Recurrent)					
Heart Problem _____					
High Blood Pressure					
Heart Problem – Type _____					
High Cholesterol					
Kidney Problem _____					
Kidney Stones _____					
Learning Disability/Dyslexia					
Liver Disease					
Migraine Headaches					
Pneumonia					
Positive Tuberculosis Test					
Premature Birth					
Psoriasis					
Seasonal Allergies					
Seizure Disorder					
Scoliosis					
Strep Throat (Recurrent)					
Stomach Ulcers					
Thyroid Disease					
Other:					

Surgery	Y	Date
Appendix		
Gallbladder		
Tonsils		
Adenoids		
Tubes in Ears		
Other:		

Immunizations	Date
Chicken Pox Vaccine	
HPV Vaccine for Girls/Gardasil	
Hepatitis B Vaccine	
Meningitis Vaccine	
Tetanus/Pertussis Vaccine	

Shoal Creek

Family Medicine & Allergy

Name: _____ Date: _____

Other Hospitalizations: (Reasons and Dates)			
Medication Allergies and Reaction:		<input type="checkbox"/> No Known Drug Allergies	<input type="checkbox"/> Bees or Wasps
<input type="checkbox"/> Penicillin <input type="checkbox"/> Sulfa <input type="checkbox"/> Mycins <input type="checkbox"/> Aspirin <input type="checkbox"/> Codeine <input type="checkbox"/> Hydrocodone			
Other Medications:			
Food Allergies:			
Current Medications: (Include Dose and Frequency)			<input type="checkbox"/> None
1.			6.
2.			7.
3.			8.
4.			9.
5.			10.
Social History and Habits:			
Current Smoker: (Y) (N) Packs/Day (___) Number of Years (___)		Chew Tobacco: (Y) (N)	
Any smokers in Household: (Y) (N) Who: _____			
Use Alcohol: (Y) (N) Frequency (Daily/Weekly/Monthly) Avg Number Drinks/Day (____)			
Currently Use Illicit Drugs: (Y) (N) Type: _____			
Exercise: Frequency (_____) Type: _____			
Sports/Extracurricular Activities: _____			
School Performance: A B C D F			
Work: Position _____		Name of business _____	
Pets: _____			
Is there any family history of someone dying younger than age 50 from a heart condition? (Y) (N)			
Women: Menstrual & Pregnancy History		Regular Cycles: (Y) (N)	
Age a onset of periods: (____)	Flow: Light/Avg/Heavy	Cramps: (Y) (N)	
Duration of Period: _____ Days	Pregnancies: (____)	Abnormal Pap: (Y) (N)	
Length of time between periods: _____ Wks	Last Pap Smear: _____	Children: (____)	
Have you missed 3 or more periods in the last year? (Y) (N)			