

INITIAL HEALTH QUESTIONNAIRE TEENS

(please print)

Name of Patient: _____ D.O.B. _____ M___ F___
Form Completed by: _____ Relationship to Patient: _____ Date Completed: _____

Medications: include all prescription, nonprescription, maintenance & as needed meds

Name _____ Dose _____ How often? _____

Name _____ Dose _____ How often? _____

Other: _____

Allergies: please specify type, reaction (hives, swelling, etc.), severity (mild, moderate or severe) & interventions (benadryl, epi pen, etc.)

To Medications _____ To Food _____ Insects, Animals, Other _____

Immunizations: Up-to-date? Yes ___ No ___ PLEASE BRING OR FAX RECORDS.

Birth History:

Problems during the hospital course _____

Development:

Reached milestones at a normal age: Yes ___ No ___ Not sure ___

Delayed? Yes ___ No ___; If yes, in what area? _____

History of Childhood Illnesses: No ___ Yes ___ *If so, list the date of illness* _____

History of Hospitalizations: No ___ Yes ___ *If yes, please give details.*

Date _____ Location _____ Reason _____

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History of Surgeries: No ___ Yes ___ *If yes, please give details.*

Date _____ Location _____ Procedure Performed _____

History of Injuries: No ___ Yes ___ *If yes, please give details.*

Location/Type of Injury _____ Date _____ Treatment _____

Prior Screening Tests: (Y/N and results)

Anemia Screening ___ Lead Screening ___ Tuberculosis ___ Prior Allergy Skin Tests ___ Hearing

___ Vision ___ Psychological Tests ___ Cholesterol ___

Family Medical History indicate who in relationship to child has the following problems...

Unremarkable (Please select this if all answers below are no) _____

Gastrointestinal Problems	_____	High Cholesterol	_____
Deafness	_____	Anemia	_____
Nasal Allergies	_____	Liver Disease	_____
Asthma	_____	Kidney Disease	_____
Bronchitis	_____	Bedwetting >10yrs old	_____
Wheezing	_____	Epilepsy, Seizures or Convulsions	_____
Mental Illness	_____	Autism	_____
Heart Disease <50yrs old	_____	Alcohol Abuse	_____
Heart Attack <50yrs old	_____	Drug Abuse	_____
Blood Pressure <50yrs old	_____	Genetic Disorders	_____
Migraines	_____	Other Immune Problems	_____
Diabetes <50yrs old	_____	Skin Conditions	_____
Cancer; list type	_____		

Social History

General:

Parent Information: Married ___ Separated ___ Divorced ___ Single Parent ___

Legal Guardian _____

Pets: Yes___ No___; If so, what type & how many? _____

Smoking: Yes___ No___; If so, where? _____

Alcohol Use: No ___ Yes ___ Drug Use: No ___ Yes ___

Guns in the household: Yes___ No___; If yes, are the guns locked & separate from ammunition? ___

Name of School _____ Grade _____

GPA &/or Grades on Last Report Card _____

Problems: _____

Adolescent Female History:

Onset of menses _____ LMP _____ Problems _____

If >16yrs, have you been taught a self breast exam? _____

Do you perform it monthly? _____ Have you been to see a Gynecologist? _____