Lossio Pediatrics, PLLC

Adolescent Health History

Ages 13-18 years

Date: _____

Name: _____ Age: _____ Birthdate: _____

Sex: ❑ Male ❑ Female Grade in School: _____ Religion: _____

Reason for visit: _____

Current Health Status: ❑ Excellent ❑ Good ❑ Fair ❑ Poor Date of Last Physical: _____

Please place a mark in the box next to any of the following that you have:

❑ Hearing problems ❑ Difficulty seeing ❑ Difficulty reading ❑ Other disabilities

If "other" is marked please list: _____

How do you prefer to learn? ❑ Written/visual material ❑ Verbal teaching

Is your primary language English ❑ Yes ❑ No If no, please list: _____

Have you ever had any surgeries: ❑ Yes ❑ No If yes, please list: _____

Medical History: (check if you currently have or have had in the past)

❑ Chest pain	❑ Allergies/Hayfever	❑ Nosebleeds
❑ Depression	❑ Weight loss	❑ Sinus Problems
❑ Excessive hunger	❑ Constipation	❑ Blood in Urine
❑ Excessive thirst	❑ Diarrhea	❑ Painful Urination
❑ Earache	❑ Nausea	❑ Persistent Cough
❑ Ear Drainage	❑ Vomiting	❑ Irregular/rapid heart beat
❑ Fainting	❑ Shortness of Breath	❑ Vision Problems
❑ Headache	❑ Rash	

Check any of the following illnesses you have or have had:

❑ Measles	❑ Diphtheria	❑ Cancer
❑ Mumps	❑ Pertussis (whooping cough)	❑ Diabetes
❑ Rubella	❑ Aids	❑ Epilepsy
❑ Roseola	❑ Alcoholism	❑ Heart Disease/Murmur
❑ Chicken Pox	❑ Anemia	❑ Venereal Disease
❑ Scarlet Fever	❑ Anorexia	❑ Hepatitis
❑ Rheumatic Fever	❑ Asthma	
❑ Polio	**Other:** _____	

Males Only:

Do you have pain in your testicles: ❑ Yes ❑ No
Do you do self testicular exams: ❑ Yes ❑ No
Do you have a discharge from your penis? ❑ Yes ❑ No
Do you have a sore on your penis? ❑ Yes ❑ No

Females Only:

At what age did your period start _____
How often is your period _____ How many days does your period last _____
Do you experience pain with your periods? ❑ Yes ❑ No
Have you ever been pregnant? ❑ Yes ❑ No
Do you do self breast exams? ❑ Yes ❑ No

Prenatal History:

Where were you born: _____ Were you premature: _____
Did you have any complications or problems at birth: ❑ Yes ❑ No
If yes what were they? _____
Did your mother smoke, or use alcohol and/or drugs during pregnancy? ❑ Yes ❑ No
If yes, what was it? _____

Hospitalizations/Surgeries/Injuries:

List all including date, where, and why, and any outpatient procedures

1. _____
2. _____
3. _____
4. _____
5. _____

Current Medications:

	Name	Dosage	When Prescribed
1.			
2.			
3.			
4.			
5.			

Do you take any over the counter medications? ❑ Yes ❑ No (If yes please list)

Allergies:

Medications:			
Foods:			
Other:			

Ever been tested for allergies: ❑ Yes ❑ No If yes when _____ Results _____

Immunizations: (list date of last or "X" if never received)

MMR: _____ Tetanus Booster: _____

DPT: _____ Pneumonia: _____

Polio: _____ TB Test: _____ results: _____

HIB: _____ Hepatitis B: _____ titer results: _____

Flu: _____

Self Care/Health habits: (the following includes questions regarding current health habits, sexuality and use of drugs and alcohol, please answer honestly, all information is considered confidential and will not be shared with anyone other than your healthcare provider without your permission)

1. Are you often sad or depressed? ❑ Yes ❑ No
2. Are you often nervous or tense? ❑ Yes ❑ No
3. Do you feel something is wrong with your weight? ❑ Yes ❑ No
4. Have you ever thought of killing yourself? ❑ Yes ❑ No
5. Have you ever been in trouble at school? ❑ Yes ❑ No
6. Have you ever been in trouble with the police? ❑ Yes ❑ No
7. Is there violence or abuse in your home: ❑ Yes ❑ No
8. Have you ever been touched in a way that made you feel uncomfortable? ❑ Yes ❑ No
9. Have you ever been physically, emotionally or sexually abused? ❑ Yes ❑ No
10. Do you have a boyfriend or girlfriend? ❑ Yes ❑ No
11. Have you been or are you currently sexually active? ❑ Yes ❑ No
12. Do you use birth control? ❑ Yes ❑ No
13. What type of birth control do you use? (check all that apply)
    - ❑ Birth control pills
    - ❑ Condoms
    - ❑ Depoprovera
    - ❑ Diaphragm
    - ❑ Spermicidal gels/foam
    - ❑ Withdrawal
    - ❑ Nothing
    - ❑ Other: _____
14. Please check any of the following substance you are currently using or have used in the past?
    - ❑ Cigarettes
    - ❑ Cocaine/Crack
    - ❑ Chewing tobacco/Snuff
    - ❑ Glue/Aerosol Cans
    - ❑ Marijuana
    - ❑ LSD/PCP/Peyote
    - ❑ Steroids
    - ❑ Beer/Wine
    - ❑ Amphetamines/Speed
    - ❑ Liquor such as whiskey, vodka etc.

Any other drugs or alcoholic beverages you use or have used: _____

15. Do you feel that you have a problem with drugs or alcohol? ❑ Yes ❑ No
16. Do you feel anyone in your family has a problem with alcohol or drug use? ❑ Yes ❑ No
17. Has anyone ever told you that you have problem with drugs or alcohol? ❑ Yes ❑ No
18. Do you have any questions regarding sex, sexuality, birth control, alcohol or drug use or any other questions regarding your health? ❑ Yes ❑ No

Family History: check if your blood relatives have had any of the following

- ❑ Arthritis
- ❑ Asthma
- ❑ Cancer
- ❑ Diabetes
- ❑ Heart Disease
- ❑ Hypertension
- ❑ Tuberculosis
- ❑ Glaucoma
- ❑ Epilepsy
- ❑ Kidney Disease
- ❑ Thyroid Disease
- ❑ Stroke
- ❑ Mental Illness
- ❑ Chemical Dependency

Thank you for taking the time to complete this form. The Information you provided will be helpful in planning your heath care.

Person completing form: _____ Relationship if not patient: _____