BRADFORD FAMILY MEDICINE, INC.
ADOLESCENT NEW PATIENT HISTORY

Patient Name:_________________________________ **Date of Birth:**__________**Today's Date:**_________
(Last) (First) (MI)
Parent/Guardian:____**Relationship:**______________________

Medication Allergies: (Please list all medication allergies and the reaction that occurred)
1.______________________________________ 3.______________________________________
2.______________________________________ 4.______________________________________

Medical Problems: (Please list all past medical problems and hospitalizations)
1.____
2.____
3.____
4.____
5.____

Previous Surgeries:
1.____
2.____

Medications: (Please include medication name/dose/frequency as well as any over-the-counter and herbal meds)
1.______________________________________ 3.______________________________________
2.______________________________________ 4.______________________________________

OB/GYN Information: (Females only-If applicable)
Age when you began your periods:_________________How long do they last?____________________
Are they regular?________________# Days:________Heavy/Moderate or Light Flow?_____________
List number of pregnancies:_____List number of full term deliveries:_____Preterm deliveries:_________
List number of ectopics:_____Miscarriages:_______Terminations:_______Living children:__________
Have you ever had an abnormal pap smear? (list details):______________________________________

Routine Health Screening: (Please list dates if applicable)
Please provide a copy of your immunizations to date.
Date of last routine well child visit:____

Dental Care: (If applicable)
Last dental exam:____________________________Dentist:___________________________________

Social History:
Tobacco/Nicotine:
Do you smoke/chew?_____Vape?_____Amount:________Year you began/quit:__________________
Alcohol/Drugs:
Do you drink alcohol?_____Type/Amount/Frequncy:____
Do you use marijuana?_____Amount/Frequency:____
Have you used other drugs?________Type(s)/Amount/Frequency:_____________________________
Diet/Exercise:
Do you follow a special diet?_______Type:____
Do you exercise regularly?________Type/Frequency:____
Sexual History (Males and Females):
Have you had sexual intercourse?_____Number of lifetime partners?___________________________
Prior sexually transmitted infections?____
List type(s) of birth control (including current):____

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Household Information/Injury Prevention:

Household Members:____
Do you feel safe in your home/current relationship?_____________________________________
Do you have smoke alarms installed?____Carbon monoxide detectors:_____Anyone smoke at home?:____
Do you use car seats/wear seatbelts?______List any pets at home:_____________________________

School/Employment:

Name of school:____Grade:______________________
Sports/extracurricular involvement:____
Issues with school performance:____
Current employment (if applicable):____

Family History:

Relative	Alive	Current Age/ Age of Death	Health Issues/Cause of Death (include all known issues including cancer types/stroke/heart issues /diabetes/etc.)
Father			
Mother			
Siblings			
Paternal Grandfather			
Paternal Grandmother			
Maternal Grandfather			
Maternal Grandmother			
Other			