Adolescent Initial History (11-20 yrs)

Today's date_____

Full Legal Name:_____ **Date of Birth**_____

FAMILY HEALTH CENTER OF MISSION

Please complete the following questions: Indicate Yes/No or Check ☑ any that apply.

Birth History:

What was your birth weight? _____lbs _____oz Was the birth: ___ Vaginal ___ Cesarean section

Blood Type: ___A ___B ___AB ___O ___Positive ___Negative

Were there complications at birth? __ Prematurity __ Newborn Infection __ Jaundice __Maternal diabetes __None
If any other complications, please explain:_____

Did you have any developmental problems? ___Yes ___No ☑ **Check any that apply.**
___ Delayed speech ___ Delayed walking ___ Poor growth ___ Poor weight gain ___ Other: _____

Medical History:

Do you have any allergies to medicines? ___Yes ___No
Name medicine and type of reaction_____

Do you have any health problems? ___Yes ___No List Problems:_____

Have you ever been hospitalized for an illness, operation, or injury? ___Yes ___No
If yes, give age and reason._____

Have you had any serious injuries? ___Yes ___No
If yes, give age and describe injury_____

Do you take any medications regularly? ___Yes ___No
List medications: _____

Have you personally used (☑ the ones used) ___tobacco, ___illegal drugs/substances, ___alcohol? ___None used

Do you exercise regularly? ___Yes ___No **Type of exercise:**_____**(**ex: swimming, jogging**)**
Frequency of exercise _____**(**ex: 3 days a week**)**

Indicate amount of time spent watching TV and/or playing Computer Games: ___hours a day ___minutes a day

Check any of the following problems you may have had. Check ☑ any that apply.

___Acne	___Headache	___Tuberculosis	___Sickle cell anemia
___Asthma	___Hepatitis	___Vision Problems	___Stomach ulcer
___Chickenpox	___Bladder Infection	___Hearing Problems	___Heart disease
___Depression	___Mononucleosis	___Seizures/epilepsy	___Diabetes
___Emotional Problems	___STD's	___Scoliosis/back problems	___Thyroid
___Cancer	Other:_____		**If None Apply ☑ box** ☐

List any specific health concerns you may have:_____

Family History:

If family member has had a history of these illnesses, **Check ☑ to indicate.**

	Cancer	Cholesterol	Diabetes	High Blood Pressure	Heart Disease	Alcoholic	Drug Abuse	If None Apply ☑ box
Father	_____	_____	_____	_____	_____	_____	_____	☐
Mother	_____	_____	_____	_____	_____	_____	_____	☐
Brother	_____	_____	_____	_____	_____	_____	_____	☐
Sister	_____	_____	_____	_____	_____	_____	_____	☐

With whom do you live? ___Mother/Father ___Stepparent ___Relative ___Other:_____

Changes in your household/family in the past year:_____
Example: Marriage, Illness, Births, Divorce, Death, Separation, Loss of job

Have you ever lived away from home? Explain_____

Are any of the following used in the home? : ___Tobacco ___Alcohol ___Illegal Drugs ___Guns ___**NONE**

Are these available in the home?: ___Telephone ___Automobile ___Thermometer ___**NONE**

Form filled out by: ___Adolescent ___Parent/guardian ___Other_____ **Form Complete:_____(staff initials)**