Health Maintenance Exam Age 13-18

NAME: _____ Age: _____Appointment Date: _____

Any new family health problems?
Who lives in your home?
School child attends?

NEW OR CONTINUING PROBLEMS:
(circle any that apply)

General: Fevers or chills. Weight change. Appetite change.
Eyes: Vision concerns. Eye discharge or discomfort.
Eye care provider and last exam:
Ears: Change in hearing or ear pain. Nasal congestion or bleeding.
Mouth: Mouth sores, sore throat, dental problems
Dental provider and last exam:
Heart: Chest pain or heart concerns
Lungs: Cough or shortness of breath.
Breasts: Pain, nipple discharge or masses
Bowels: Abdominal pain, change in bowels, bleeding, heartburn
Urinary: Urinary problems, menstrual problems
Muscle/bone: Injuries, joint or muscle or back pain
Brain, spine: Headaches, coordination problems
Skin: Rashes or concerning lesions
Metabolism: Unusual thirst or weight loss.
Emotions: Depression or anxiety; school problems, fears
Allergy: Allergy symptoms

MEDICATIONS (PRESCRIPTION AND NON-PRESCRIPTION):

MEDICATION ALLERGIES:

Sleeping - typical wake and sleep times

Any problems at home or at school?

Favorite activities?

How many hours of TV per day? TV in your room?

How often do you use your seat belt?

How many meals do you eat per day?