

HEALTH HISTORY NEW PATIENT AGE 13-18

NAME:

_____ Birthdate: _____ Age: _____

Past Health History

List any problems as infant or young child:

List any hospital stays or surgeries:

Immunization history:

Current medications and supplements (prescription and over the counter)

Allergies:

Tobacco use:

By you –

By anyone in your home –

Alcohol or drug use:

By you –

By anyone in your home that concerns you–

Sodas per week:

Circle any problems or questions you have regarding:

Weight gain or loss

Fever, chills, night sweats

Headaches, head injuries, concussion

Eye problems, do you wear contacts or glasses?

Dental problems, braces

Cold or allergy symptoms, nose bleeds

Ear problems, hearing loss, ringing, ear pain

Thyroid problems

Breast masses, breast discharge, breast pain

Breathing problems, shortness of breath, asthma

High blood pressure, chest pain, palpitations

Heartburn, ulcers, constipation, diarrhea, bloody

black bowel movements, abdominal pain

Kidney or bladder infection, pain with urination

Muscle pain, joint pain or swelling, broken bones,
sprains

Seizure, loss of coordination

Rash, mole change, skin infections, hair loss

Depression, poor sleeping, appetite problems,
panic attacks, suicidal thoughts or attempts

Concerns about sexuality or sexual function?

Females: Periods started at age_____

Problems with your periods_____

Family Health History

Father's name:

Health problems:

Mother's name:

Health problems:

Sibling's names:

Health problems:

Other family members with health problems you feel
are important for us to know:

Your current situation:

School you attend –

Who lives at home with you –

Current activities –

ANY OTHER CONCERNS NOT LISTED HERE?

THANK YOU!