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!

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Barbara J. Lukas, RN, FNP-C