FAMILY HEALTH
ASSOCIATES

Derek T. Earl, DO, CIC | Jonas H. Oltman, DO | Shara M. Salverda, FNP | Jessica L. Oltman, FNP-C | Dawn R. Headings, FNP- BC | John R. Adair, PA-C | Maria A Faaeteete, FNP-C

ADOLESCENT MEDICAL HISTORY (ages 12 – 18)

Patient Name: _____ Date: _____

To be completed by adolescent, parent or guardian. Please answer all questions to the best of your ability.

1. Has patient had an allergic reaction or intolerance to any of the following (Circle all that apply)?

No allergies Shellfish Peanuts Latex (rubber gloves) Bee Stings Eggs
No intolerances Medications: _____ Other:_____

2. Is patient taking any over the counter medications, prescriptions or drugs? □ YES □ NO
Please describe _____

3. Are there any cultural or religious practices that might affect your child's medical care?
□ **YES** Please explain _____ □ **NO**

3. Please circle any conditions or symptoms the patient has or has had on the list below.

- Allergies *(seasonal, hay fever, etc.)*
- Asthma
- Autoimmune disorder
- Blood disorders
- Urinary, Kidney, Testicle problems
- Eating disorders *(throwing up, not eating, or eating too much)*
- Heart problems
- High cholesterol
- Learning disability or special education needs
- Chest pain, difficulty breathing, coughing or wheezing with exercise
- Mental health condition *(anxiety, ADHD, depression, etc.)*
- Broken bones? Where_____
- Autism Spectrum Disorder
- Period Problems
- Stomach problems Type: _____
- Cavities, tooth pain or injury
- Dizziness, fainting, or heat related illness
- Headaches or migraines
- Head injury, concussion or seizures
- Missing or damaged organs *(kidney, eye,*
- *testicle)* Which? _____
- Problems since birth, genetic disorders
- Cancer - Type:_____

Other:_____

Is there any reason why adolescent should not participate in sports or has ever been refused participation for a medical reason? YES/NO

4. Has patient had any surgeries, major injuries, or been in the hospital overnight? □ YES □ NO
If yes, please explain _____

_____

ADOLESCENT MEDICAL HISTORY (ages 12 – 18)

Patient Name: _____ Date: _____

ORAL HEALTH

9. Does patient visit the dentist regularly (at least once a year)? □ YES □ NO
When was the last visit? _____

10. Does anyone in the home smoke cigarettes: □ YES □ NO

HEALTH CONCERNS

11. Do you have any concerns about health or safety that you would like to discuss? □ **YES** □ **NO**

12. Do you have questions or concerns regarding tobacco, alcohol or drug use? □ **YES** □ **NO**

13. Do you have concerns about school work or attendance? □ **YES** □ **NO**

14. Are there any concerns of sadness, worrying, depression, feelings or behaviors that seem out of the ordinary for the patient? □ **YES** □ **NO**

15. Do you have concerns about sexual activity? □ **YES** □ **NO**

16. Are there any other concerns the provider should know about? □ **YES** □ **NO**
If yes, please explain:
_____

17. Within the last 12 months, I worried our family would run out of food or we didn't have enough? Often Sometimes Never Don't know

18. Do not have permanent housing? □ **YES** □ **NO** If no, please explain _____
_____

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ADOLESCENT MEDICAL HISTORY (ages 12 – 18)

FAMILY MEDICAL HISTORY

Medical problems can run in families. Please circle below any health problems of the patient's family member(s).

Any relatives that have died before the age of 50? □ **YES** □ **NO** If yes, what was the case of death (if known)? _____

Mother (Biological): Living? □ YES □ NO □ DON'T KNOW

Has no medical problems Diabetes Kidney problems Heart problems
Stroke/blood clots Alcohol/drug abuse High blood pressure
Cancer: Type_____ Mental health conditions : Depression, anxiety, ADHD, bipolar disorder
Other: _____

Father (Biological): Living? □ YES □ NO □ DON'T KNOW

Has no medical problems Diabetes Kidney problems Heart problems
Stroke/blood clots Alcohol/drug abuse High blood pressure
Cancer: Type_____ Mental health conditions : Depression, anxiety, ADHD, bipolar disorder
Other: _____

Sister(s)/Brother(s) (Biological): Living? □ YES □ NO □ DON'T KNOW

Has no medical problems Diabetes Kidney problems Heart problems
Stroke/blood clots Alcohol/drug abuse High blood pressure
Cancer: Type_____ Mental health conditions : Depression, anxiety, ADHD, bipolar disorder
Other: _____

Patient Name: _____

Patient Signature: _____ **Date** _____

Parent or Guardian Signature: _____ **Date** _____