FAMILY HEALTH
ASSOCIATES

Derek T. Earl, DO, CIC | Jonas H. Oltman, DO | Patrick B. Johansing, 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 | Jadie A. Dolan, FNP-C

ADOLESCENT MEDICAL HISTORY (AGES 12-18)

Patient Name: _____ **Date**: _____

To be completed by adolescent, parent or guardian. If parent or guardian is completing, please answer questions about your child's health history. Skip any questions that you do not know the answer to.

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

No allergies Shellfish PeanutsLatex (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

4. Please check 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
☐Cholesterol
☐Learning disability or special education needs
☐Chest pain, difficulty breathing, coughing or wheezing with exercise
☐Mental health condition (ADHD, depression, anxiety, etc.)
☐Broken bones? Where _____
☐Autism spectrum disorder
☐Cavities or tooth pain/injury
☐Dizziness, fainting, or heat related illness
☐Headaches/migraines
☐Head injury, concussion or seizures
☐Missing or damaged organs (kidney, eye, testicle)
☐Problems since birth/Genetic disorders
☐Cancer type:_____
☐Other: _____
☐Is there any reason why adolescent should not participate in sports or has ever been refused to participation for a medical reason? ☐ **Yes** ☐ **No**
☐ Stomach problems Type_____
☐Period problems

FAMILY HEALTH
ASSOCIATES

Derek T. Earl, DO, CIC | Jonas H. Oltman, DO | Patrick B. Johansing, 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 | Jadie A. Dolan, FNP-C

ADOLESCENT MEDICAL HISTORY (AGES 12-18) cont.

5. Has patient had any surgeries, major injuries, or been in the hospital overnight?

☐**Yes** ☐**No** If yes, please explain: _____

_____

ORAL HEALTH

6. Do you go to the dentist regularly (at least once a year)? ☐ Yes ☐ No Last Visit: _____

FAMILY MEDICAL HISTORY

Medical problems that can run in families. Please circle below to tell us about any health problems your family member has had.

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

Has no medical problems	Diabetes	Kidney problems	Heart problems
Stroke/blood clots	Alcohol/drug abuse	High blood pressure	

Cancer: Mental health conditions:
Type_____ Depression, anxiety, ADHD, bipolar disorder

Other: _____

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

Has no medical problems	Diabetes	Kidney problems	Heart problems
Stroke/blood clots	Alcohol/drug abuse	High blood pressure	

Cancer: Mental health conditions:
Type_____ Depression, anxiety, ADHD, bipolar disorder

Other: _____

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

Has no medical problems	Diabetes	Kidney problems	Heart problems
Stroke/blood clots	Alcohol/drug abuse	High blood pressure	

Cancer: Mental health conditions:
Type_____ Depression, anxiety, ADHD, bipolar disorder

Other: _____

FAMILY HEALTH
ASSOCIATES

Derek T. Earl, DO, CIC | Jonas H. Oltman, DO | Patrick B. Johansing, 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 | Jadie A. Dolan, FNP-C

ADOLESCENT MEDICAL HISTORY (AGES 12-18) cont.

7. Does anyone in your home smoke cigarettes: ☐Yes☐No

HEALTH CONCERNS – PARENT/GAURDIAN TO COMPLETE

8. Do you have any concerns about your child's health or safety you would like to discuss? ☐Yes ☐No

9. Do you have concerns that your child may be using tobacco, alcohol or drugs? ☐Yes ☐No

10. Do you have concerns about your child's school work or attendance? ☐Yes ☐No

11. Does your child seem sad, worried, depressed, or express feelings or behaviors that seem out of the normal for someone his/her age? ☐Yes ☐No

12. Within the last 12months – I worried if our family would run out of food before I got more money to buy more OFTEN / SOMETIMES / NEVER / DON'T KNOW

13. Within the last 12 months the food we bought just didn't' last as we didn't have money to get more? OFTEN / SOMETIMES / NEVER / DON'T KNOW

14. What is your current housing situation? WE HAVE PERMANANET HOUSING / WE DO NOT HAVE PERMANENT HOUSING / WE LIVE WITH OTHERS / ON THE STREET, CAMP, BRIDGE / IN A SHELTER/ IN TRANSITIONAL HOUSING.

Patient Signature: _____

Parent/Guardian Signature:_____