

HISTORY
THIRTEEN THROUGH EIGHTEEN YEARS

PATIENT NAME: _____

DATE OF BIRTH: _____

IMMUNIZATIONS:

CIRCLE ONE:

- | | | |
|---|----|-----|
| 1. Do you have your immunization records with you today | No | Yes |
| If not, please bring them on your next visit. | | |
| 2. Did you get your "DPT" immunization as an infant | No | Yes |
| 3. Date of last tetanus booster _____ | | |
| 4. Have you had the oral polio vaccine | No | Yes |
| 5. Have you had a TB skin test | No | Yes |
| 6. Have you had both MMR shots (Measles, Mumps, Rubella)..... | No | Yes |

PAST HISTORY:

- | | | |
|--|-----|----|
| 1. Have you ever been hospitalized for illness or operation | Yes | No |
| If yes, Age _____ Hospital _____ | | |
| Reason _____ | | |
| 2. Any other prolonged or serious illness? | Yes | No |
| 3. Do you have any allergy (hives, wheezing, asthma, hay fever)?..... | Yes | No |
| 4. Have you ever had a reaction (rash, hives, breathing difficulty) to any medicines, or injections (such as Penicillin)?..... | Yes | No |
| 5. Are you taking any medications now | Yes | No |
| If yes, which ones? _____ | | |

FAMILY-SOCIAL HISTORY:

- | | | |
|---|-----|-----|
| 1. Are there any members of your immediate family (brothers, sisters, parents, grandparents aunts or uncles) with a serious health problem (mental or physical)? | Yes | No |
| List each problem and who has it _____ | | |
| _____ | | |
| 2. How many people live in your home? _____ Children _____ Adults | | |
| 3. With whom do you live (circle one) | | |
| Both Parents Mother Father Legal Guardian Other | | |
| 4. Does anyone at home smoke..... | Yes | No |
| 5. Do your parents get along well with each other | No | Yes |
| 6. Do you feel that your parents understand your problems..... | No | Yes |
| 7. Any long term separations of the family | Yes | No |
| 8. Do you feel your parents (circle one): | | |
| Are too strict Favor your brothers and sisters over you Are too old fashioned | | |
| Are fair Don't care | | |
| 9: Could things be better at home | Yes | No |

ACCIDENTS:

- | | | |
|--|-----|-----|
| 1. Have you ever had any serious accidents | Yes | No |
| Burns _____ Poisoning _____ Cuts needing a doctor _____ Broken bones _____ | | |
| 2. Do you use seat belts in your car | No | Yes |
| 3. Do you know how to swim | No | Yes |
| 4. Are firearms (loaded or unloaded) kept in your home..... | Yes | No |
| 5. Do you wear a helmet when bicycling, in-line skating, skateboarding or skiing?..... | Yes | No |

PLEASE COMPLETE THE BACK OF THIS PAGE

REVIEW OF SYSTEMS:

1. Do you any of the following complaints: (circle which ones)
Headaches Difficulty hearing Dizzy spells Blurred or double vision
Convulsions Seizures Sinus trouble
2. Do you wear glasses?Yes No
If yes, for how long? _____
3. When was the last time you had your eyes checked? _____
4. Do you have swollen glands of the neck or under the arms.....Yes No
5. Have you had pneumonia more than two times?.....Yes No
6. Do you get short of breath before members of your classYes No
7. Do you smoke?Yes No
If yes, how many packs a day?_____
8. Do you have a chronic cough?Yes No
9. Do you have a heart murmur.....Yes No
10. Do you have:
Chest pain Abdominal Pain Constipation Diarrhea Frequent vomiting
11. Have you ever had hepatitis (yellow eyes or skin)?Yes No
12. Have you had joint pain or swelling in the joints?.....Yes No
13. Have you ever had a kidney infection?.....Yes No
14. Does it burn when you pass urine?.....Yes No
15. Do you get up at night to urinate?Yes No
16. Do you ever wet the bed?Yes No
17. Have you ever had sexually transmitted diseases (STD)?Yes No
18. Do you have any questions about venereal disease?Yes No
19. Have you had recurrent fevers?Yes No
20. Do you have any problems with acne?.....Yes No
21. Do you have any problems with your teeth?.....Yes No
22. Are you tired in the morning when you get up?Yes No

INDIVIDUAL PATTERNS:

1. What grade are you in?_____ Are you satisfied with your grades?Yes No
2. Do you miss more than three days of school each month?Yes No
3. Is something slowing your progress at school?Yes No
4. Do you teachers pick on youYes No
5. Is school: a drag a means to an end meaningless worthwhile
6. What do you plan to do when you graduate? _____

7. Do you make friends easily?Yes No
8. Do you often feel left out?.....Yes No
9. Do things get on your nerves easily?Yes No
10. Do you feel that you are a nervous person?Yes No
11. Do drugs make you feel better?Yes No
12. Do you take drugs when you are alone?Yes No
13. Would you like to learn more about prevention of pregnancy?.....Yes No

FOR GIRLS ONLY:

1. Have you had you first period?Yes No
If yes, at what age? _____
2. Would you like to learn more about periods?.....Yes No
3. Do you have cramping with periods.....Yes No
4. Are your periods regularNo Yes
5. Are you taking birth control.....Yes No
6. Would you like information about birth controlYes No

COMPLETED BY: _____

DATE: _____