



Urgent Medical & Family Care, PA
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ADOLESCENT PATIENT HISTORY

DATE _____

(Your answers are confidential)

NAME: _____ **With whom do you live?** _____ Mother and Father
 _____ Mother
 Do you have medicine allergies? _____ Yes _____ No
 Are you taking any medications/supplements? _____ Yes _____ No _____ Father
 Do you have any health problems? _____ Yes _____ No _____ Step Mother
 Have you ever been hospitalized overnight? _____ Yes _____ No _____ Step Father
 Have you ever had any serious injuries? _____ Yes _____ No _____ Guardian
 Have your parents or any blood relatives had a _____ Brother(s)
 stroke or heart attack before age 55? _____ Yes _____ No _____ Not Sure _____ Sister(s)
 Does either of your parents have high cholesterol? _____ Yes _____ No _____ Not Sure _____ Other

Have you ever had any of the following illness or problems? If yes, write down how old you were when the problem or illness started.

	Yes	Age		Yes	Age
Allergies/hayfever	<input type="checkbox"/>	_____	Low iron in blood (anemia)	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	_____	Mononucleosis (mono)	<input type="checkbox"/>	_____
Bladder or kidney infection	<input type="checkbox"/>	_____	Pneumonia	<input type="checkbox"/>	_____
Blood disorder/sickle cell anemia	<input type="checkbox"/>	_____	Rheumatic fever or heart disease	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	_____	Scoliosis (curved spine)	<input type="checkbox"/>	_____
Chicken pox	<input type="checkbox"/>	_____	Seizures/epilepsy	<input type="checkbox"/>	_____
Depression	<input type="checkbox"/>	_____	Severe acne	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	_____	Stomach problems	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	_____	Tuberculosis (TB)	<input type="checkbox"/>	_____
Headaches/migraines	<input type="checkbox"/>	_____	Other	<input type="checkbox"/>	_____

Please check whether you have questions or are worried about any of the following:

<input type="checkbox"/> Height/weight	<input type="checkbox"/> Frequent colds	<input type="checkbox"/> Skin (rash,acne)	<input type="checkbox"/> Masturbation
<input type="checkbox"/> Blood Pressure	<input type="checkbox"/> Mouth/teeth	<input type="checkbox"/> Muscle or joint pain	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Diet/food/appetite	<input type="checkbox"/> Neck/back	in arms/legs	<input type="checkbox"/> Trouble sleeping
<input type="checkbox"/> Future plans/job	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Frequent or	<input type="checkbox"/> Tiredness
<input type="checkbox"/> Skin (rash,acne)	<input type="checkbox"/> Coughing/wheezing	painful urination	<input type="checkbox"/> Cancer
<input type="checkbox"/> Headaches/migraines	<input type="checkbox"/> Breasts	<input type="checkbox"/> Discharge from penis	<input type="checkbox"/> Dying
<input type="checkbox"/> Dizziness/passing out	<input type="checkbox"/> Heart	or vagina	<input type="checkbox"/> Stress
<input type="checkbox"/> Eyes/vision	<input type="checkbox"/> Stomach pain	<input type="checkbox"/> Wetting the bed	<input type="checkbox"/> Physical or sexual abuse
<input type="checkbox"/> Ears/hearing/earaches	<input type="checkbox"/> Nausea/vomiting	<input type="checkbox"/> Sexual organs	<input type="checkbox"/> Other (explain)
<input type="checkbox"/> Nose	<input type="checkbox"/> Diarrhea/constipation	<input type="checkbox"/> Menstruation/periods	_____

**This information is strictly
Confidential**

HEALTH PROFILE

These questions will help us get to know you better. Your answers will only be seen by your health care provider and his/her assistant.

- | | | | |
|---|------------|------|----------|
| 1. Are you satisfied with your current weight? | Yes | No | |
| 2. Do you exercise more than once a week? | Yes | No | |
| 3. Do you wear your seat belt whenever you are riding in an automobile | Yes | No | |
| 4. How many hours do you spend on TV or video games each day? | _____hours | | |
| 5. Compared to last year, how are your grades in school this year? | Better | Same | Worse |
| 6. Have you been suspended from school this year? | Yes | No | |
| 7. Do you think your parents/guardian usually listen to you and take your feelings seriously? | Yes | No | |
| 8. In your opinion is there a lot of tension or conflict in your home? | Yes | No | |
| 9. Have you been in trouble with the law? | Yes | No | |
| 10. In the past year have you carried a gun, knife or other weapon for your protection? | Yes | No | |
| 11. Do you or anyone you live with smoke cigarettes? | Yes | No | |
| 12. Do you or anyone you live with smoke marijuana? | Yes | No | |
| 13. In the past month did you get drunk or very high on beer, wine or liquor? | Yes | No | |
| 14. Have you ever gotten into trouble because of drinking? | Yes | No | |
| 15. Does anyone in your family have a problem with drugs or alcohol? | Yes | No | |
| 16. Have you ever ridden in a car with a drunken driver? | Yes | No | |
| 17. Have you ever had sex (sexual intercourse)? | Yes | No | |
| 18. Have you ever had a sexually transmitted infection? | Yes | No | |
| 19. Have you ever been pregnant or fathered a child? | Yes | No | |
| 20. In general, are you happy with the way things are going for these days? | Yes | No | |
| 21. Have you ever been physically, sexually or emotionally abused? | Yes | No | Not sure |
| 22. Would you like to be referred for counseling about something you have on your mind? | Yes | No | Not sure |
| 23. Would you like information on how to prevent pregnancy or sexually transmitted diseases (STD) ? | Yes | No | |
| 24. What do you do best? _____ | | | |
| 25. If you could change one thing about your life or yourself what would it be?
_____ | | | |

Patient Signature _____ **Date** _____