

PEDIATRIC/ADOLESCENT PERSONAL HEALTH HISTORY Today's Date: _____

WOMEN'S WELLNESS CENTER

Name: _____ DOB: ___/___/___ Age: ___ Grade: ___

ALLERGIES None Latex Allergy? No Yes
 Medication Allergies: _____

 Food / Environmental: _____

MEDICAL HISTORY NO MEDICAL HISTORY
 Check if **YOU** have ever had any of the following
 Diabetes Asthma Blood Clots
 Low Thyroid Seizure Disorder Chicken Pox
 High Blood Pressure Anxiety Measles
 Hepatitis Passed Out Depression
 Seasonal Allergies Autoimmune Disorder
 Broken Bone(s) Location _____
 Sports Injury Location _____
 Previous Blood Transfusion: Year _____
 Sexually Transmitted Infection - Type: _____
 Abnormal Pap in the past? No Yes - Year: _____
 List treatment, if any: _____
 Other medical problems: _____

SURGICAL HISTORY NO SURGICAL HISTORY
 Check if **YOU** have ever had any of the following
 Tonsillectomy Year _____ Appendectomy Year _____
 Adenoidectomy Year _____ Gall Bladder Year _____
 Tubes in ears Year _____
 Other Surgeries: Year _____ Type _____
 Year _____ Type _____
 Year _____ Type _____

ACTIVITIES AND INTERESTS
 Do you play sports? No Yes Which ones _____

 Do you like to: read listen to music write draw & paint
 dance drama sing/in choir play in school band cheerleading

IMMUNIZATIONS: Have you received a full series of the following?
 Hepatitis A Yes - Date completed ___/___/___ No Unsure
 Hepatitis B Yes - Date completed ___/___/___ No Unsure
 HPV Vaccine Yes - Date completed ___/___/___ No Unsure
Have you received the following vaccines?
 Flu vaccine Yes - Date received ___/___/___ No Unsure
 Tetanus/TDaP Yes - Date received ___/___/___ No Unsure
 Pneumovax Yes - Date received ___/___/___ No Unsure
Have you had a TB test? No Yes Date of last test ___/___/___
 Neg. Pos. If Positive, how was it treated? _____

GYNECOLOGICAL INFORMATION:
 Age at first menstrual period: _____
 Have been pregnant? Have never been pregnant
 When was your Last Menstrual Period? ___/___/___
 What is your birth control?
 None Condoms Pills Patch
 Other: _____

FAMILY HISTORY -
 NO FAMILY HISTORY Adopted
 Check if you have any **FAMILY MEMBERS** with the following issues:
 Family Member(s)
 Breast Cancer _____
 Uterine Cancer _____
 Ovarian Cancer _____
 Colon Cancer _____
 Heart Disease _____
 Diabetes _____
 High Blood Pressure _____
 Blood Clots _____
 Sudden Death at Young Age _____

MEDICATIONS: Please include birth control pills, over-the-counter medicines, herbals and vitamins.

Medication Name	Strength	How Often	Prescribed by	Reason
<input type="checkbox"/> No medications				
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

SOCIAL HISTORY & HEALTH HABITS
 Do you drink caffeine? No Yes: _____(type) _____ servings daily
 Do you smoke? No Yes _____cigarettes/day
 Do you drink alcohol? No Yes _____drinks / week
 Do you use other substances? No Yes: _____(type) Last use: _____
 Are you sexually active? No Yes Since what age? _____ How many partners? _____

History of Abuse? No Yes
 Emotional Physical
 Do you exercise? No Yes
 Do you eat a healthy diet? No Yes
 Do you drive a car? No Yes
 Do you use a seatbelt? No Yes