WFMA

Waynesboro Family Medical Associates, LLP

ADOLESCENT HEALTH HISTORY

(Use for ages 11-20 years)

Today's Date: _____

Patient Name: _____ Date of Birth: _____ Age: _____

PAST MEDICAL HISTORY Previous doctor: ☐ None ☐ Yes (Name) _____

Allergies/reactions to medicines or vaccines: _____

Current Medications: (including vitamins, herbs, supplements, birth control pills)

Name	Dose	How many times per day	When started

Major Medical Problems: ☐ None ☐ Yes, (list) _____

Hospitalizations/ Operations: ☐ None ☐ Yes, (list) _____

Broken bones/Server Injuries: ☐ None ☐ Yes, (list) _____

REVIEW OF SYSTEMS Please check (✓) any current problems your child has on the list below:

General
___ fevers/chills/excessive sweating
___ unexplained weight loss/gain

Eyes
___ squinting/cross eyes

Ears/Nose/Throat
___ unusually loud voice/hard of hearing
___ mouth breathing/snoring
___ bad breath
___ frequently runny nose
___ problems with teeth/gums

Heart/Cardiovascular
___ tires easily with excercise
___ shortness of breath
___ fainting
___ chest pain with excercise

Lungs/Respiratory
___ cough/wheeze
___ chest pain

Gastrointestinal
___ nausea/vomiting/diarrhea
___ constipation
___ blood in bowel movement

Genitourinary
___ bedwetting
___ pain with urination
___ discharge penis or vagina

Musculoskeletal
___ muscle/joint pain

Skin
___ rashes
___ unusual moles

Allergy
___ hay fever/itchy eyes

Neurological
___ Headaches
___ weakness
___ clumsiness
___ speech problems

Psychiatric/Emotional
___ anxiety/stress
___ problems with sleep/nightmares
___ depression
___ nail biting/thumb sucking
___ bad temper/breath holding/jealousy

Blood/Lymph
___ unexplained lumps
___ easy brusing/bleeding

SOCIAL/SCHOOL HISTORY Current grade: _____ Name of School _____

Concerns about school performance? ☐ No ☐ Yes, _____

Concerns about relationships with teachers? ☐ No ☐ Yes, _____ Students? ☐ No ☐ Yes, _____

School grades: _____ Best friend? ☐ No ☐ Yes Many friends? ☐ No ☐ Yes Dating? ☐ No ☐ Yes

Sexually active? ☐ No ☐ Yes Using birth control? ☐ No ☐ Yes Would like more information? ☐ No ☐ Yes

Involved in activities /sports/excercise? ☐ No ☐ Yes (list) _____

Signature of person completing this form: _____

Reviewed by Provider: _____

ADOLESCENT HEALTH HISTORY

Patient's Name: _____ Today's Date: _____

FAMILY HISTORY

Please indicate family members (mother, father, sister, brother, aunt, uncle, grand partent

Alcoholism _____ Heart attack _____ High cholesterol _____ Stroke _____

Cancer _____ High blood pressure _____ Depression/suicide _____ Diabetes _____

In the past year, have there been any changes in your family? (check all that apply)

☐ Marriage ☐ Separation ☐ Divorce ☐ Move to new neighborhood ☐ Change to new school ☐ Serious illness

☐ Loss of job ☐ Death ☐ Birth ☐ Other changes/stresses _____

Who live at home with you?

Name	Age	Relationship

IMMUNIZATION/INFECTIOUS DISEASE

Did you bring your child's immunization record with you today?

☐ Yes ☐ No ☐ Will bring to next appointment ☐ Records with another care provider (name) _____

Has your child had: ☐ Chicken Pox ☐ Measles ☐ Mumps ☐ Rubella ☐ Tuberculosis (TB) ☐ Hepatitis B

☐ Meningitis ☐ Pneumonia ☐ Influenza (flu) ☐ Other disease _____

PREVENTION/SAFETY

What is your dentist's name? _____ Date of last dental exam: _____

Do you or does anyone in your home:

Use tobacco products? ☐ No ☐ Me ☐ Household member Type: _____ Amount: _____

Drink alcohol? ☐ No ☐ Me ☐ Household member Type: _____ Amount: _____

Use illegal drugs? ☐ No ☐ Me ☐ Household member Type: _____ Amount: _____

Does your home have smoke detectors? ☐ No ☐ Yes

Do you have a gun in your house? ☐ No ☐ If Yes, is it unloaded and out of reach? ☐ No ☐ Yes

Do you regularly use:

Helmets for bikes/boards/ATVs/motorcycles? ☐ No ☐ Yes

Seat belts when riding or driving a car? ☐ No ☐ Yes

OTHER CONCERNS

Please review this list and check any concerns you have about the patient

☐ Physical development	☐ Emotional development	☐ Sleep patterns
☐ Weight	☐ Diet/Nutritian	☐ Amount of physical activities
☐ Relationship with parents and family	☐ Choice of friends	☐ Self image/self worth
☐ Excessive moodiness or rebellion	☐ Depression	☐ Lying, stealing, vandalism
☐ Violance/gangs/guns/weapons	☐ School grades/absences	☐ Drug use
☐ Smoking/chewing tobacco	☐ Alcohol use	☐ Sexual behavior
☐ Sexual orientation (heterosexual, gay)	☐ Pregnancy risl	☐ Sexually transmitted diseases (STDs)

What is the greatest challenge for you/your child? _____

What about you/your adolescent makes you proud? _____

Is there anything you would like to discuss in private today? _____

Signature of person completing this form: _____

Reviewed by Provider: _____