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)_____

Hospitalization/Operations:__None __ Yes, (list) _____

Broken bones/Severe 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

Eyes
__ squinting/cross eyes

Ear/Nose/Throat
__ unusually loud voice/hearing issue
__ mouth breathing/snoring
__ bad breath
__ frequently runny nose
__ problems with teeth/gums

Heart/Cardiovascular
__ tires easily
__ shortness of breath
__ fainting
__ chest pain with exercise

Lungs/Respiratory
__ cough/wheeze
__ chest pain

Gastrointestinal
__ nausea/vomiting/diarrhea
__ constipation
__ blood in bowel movements

Genitourinary
__ bedwetting
__ pain with urination
__ discharge penis/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
__ depression
__ nail biting/thumb-sucking
__ bad temper/jealousy

Blood/Lymph
__ unexplained lumps
__ easy bruising/bleeding

SOCIAL/SCHOOL HISTORY Current grade:____ Name of school _____

Concerns about school performance? __ No __Yes, _____

School grades:_____ Best friend? __No __Yes Many friends? __No __Yes,_____

Sexually active? __No __Yes Using birth control? __No __Yes Need more information?_____

Signature of person completing this form: _____

Reviewed by Provider:_____

ADOLESCENT HEALTH HISTORY

Patient's Name:_____

_____

FAMILY HISTORY Please indicate family members (mother, father, sister, brother, aunt, uncle, grandparent)

Alcoholism _____ Heart attack_____ High cholesterol_____ Diabetes____
Stroke_____Cancer_____ Stroke_____ High blood pressure_____
Depression/suicide_____

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

__ Marriage __Separation __Divorce __ Move to a new neighborhood __New school
__Serious illness __Loss of job __Death __Birth __Other changes/stresses

Who lives at home with you?

Name	Age	Relationship

IMMUNIZATION/INFECTIOUS DISEASE Did you bring your child's immunization history?____
If not, will you bring to next appointment? Or are they with another care provider?_____
Has your child had: __Chicken pox __Measles __Mumps __Rubella __Tuberculosis __HepB
__ Meningitis __ Pneumonia __ Influenza __ Other disease _____

_____

PREVENTION/SAFETY

What's your dentist 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 guns in your home? __No __ Yes If yes, are they unloaded and out of reach? ___
Do you regularly use: Helmets for bikes/boards/atvs/motorcycles? __ Yes __ No
Seat belts when riding or driving a car? __ Yes __ No

_____

OTHER CONCERNS Please review this list and check an concerns you have:

__ Physical development __ Emotional development __Sleep patterns __ Weight __Diet
__ Physical activities __ Relationship with family/friends __ Choice of friends __Self image
__ Self worth __ Excessive moodiness or rebellion __ Depression __ Lying, Stealing
__ Violence/gangs/guns/weapons __School grades/absences __Drug Use
__Smoking/chewing tobacco __ Alcohol use __Sexual behavior __Sexual orientation
__Pregnancy risk __ Sexually transmitted diseases (STDs)

What is the greatest challenge for you/your child? What makes you proud?_____
Is there anything to discuss in private today?_____

_____

Signature of person completing this form: _____
Reviewed by provider:_____