ADOLESCENT HEALTH HISTORY

Ages 11-17

Patient Information	**Today's date:**
Name on insurance: Last: First:	**Name you go by:** Last: First:
Date of birth:	**Pronouns:**
Legal Guardian Name(s):	**Relationship to patient:**
Primary language: **Do you need an interpreter?**	**Preferred pharmacy:**
Race:	**Ethnicity:**
Sex assigned at birth: __ Male __ Female __ Intersex **Legal sex:** __ Male __ Female __ X	**Gender identity:**
Sexual orientation: __ Gay/Lesbian __ Bisexual __ Heterosexual __ Something else:	**Grade in school:** **Do you work?** __ Yes __ No **Occupation:**
Are you transferring care from another provider: __ Yes __ No	**If yes, name and phone of previous provider:**

What are your main reasons for coming to the clinic today: *Please note priority.* __ Establish primary care

_____

_____

_____

Health History

__ No allergies

__ Need epi pen

__ See attached

Allergen	Reaction	Severity	Age of onset

__ None

__ See attached

Medication	Dose	Frequency	Reason prescribed

__ None

__ See attached

Supplement	Dose	Frequency	Reason taking

List all known illnesses/diagnosis, major events (surgeries, hospitalizations, accidents) and imaging. If applicable, include providers name and contact information.

Diagnosis	Date	Specialist Name	Clinic Contact

Major events: surgeries, hospitalizations, accidents	Date	Imaging (x-ray, MRI, CT, ultrasound, ECG, echo, etc)	Clinic Contact

Vaccine	Date	Vaccine	Date
TDaP (tetanus, diphtheria, pertussis)		DTaP	
Rotavirus		Seasonal Flu	
Haemophilus flu		Pneumococcal	
Poliovirus		Varicella/Chicken Pox	
Hep A		Hep B	
MMR (measles, mumps, rubella)		Meningococcal	
HPV/Gardasil		COVID	
Other vaccines:			

Family Health History - (Please include cancers, hypertension, substance abuse, diabetes, cardiac diagnoses, etc)

Relationship	Age if living	Age of death	Medical history
Mother			
Maternal grandmother			
Maternal grandfather			
Father			
Paternal grandmother			
Paternal grandfather			
Sibling			

Social History & Safety Screening	
Who do you live with?	Family members in the home:
Do you have enough to eat? __ Yes __ No	Are you in stable housing? __ Yes __ No
Do you have smoke and carbon monoxide detectors in your home? __ Yes __ No	Do you have moisture problems in your home? __ Yes __ No
Do you have stable transportation? __ Yes __ No	Do you experience bullying? __ Yes __ No
Do you have guns in your home? __ Yes __ No If yes, are they safely stored? __ Yes __ No	Do you wear seatbelts in the car? __ Yes __ No Do you wear helmets when recommended? __ Yes __ No
Tobacco use: __ Never use __ Former use __ Current use	Alcohol use: __ Never use __ Former use __ Current use

Type of tobacco product(s) used: If you are a smoker, how many packs per day? Start date: Quit date:	If you drink, how many drinks per week? Would you like to talk about quitting? __ Yes __ No
Substance use: __ Never use __ Former use __ Current use	Substance(s) used: History of IV drug use? __ Yes __ No Would you like Narcan today? __ Yes __ No
Are you sexually active? __ Yes __ Not currently __ Never	Contraceptives/Protection used: __ Abstinence __ Cervical cap __ Condom __ Diaphragm __ Patch __ Implant __ Injection __ IUD __ Pills __ Vaginal ring __ Sterilization __ Fertility awareness __ Pull out
Partner(s) sex assigned at birth (this helps us assess overall risk):	Have you ever tested positive for an STI? __ Yes __ No If yes, what did you test positive for?
In the past year, how often would you estimate someone has done any of the following to you?	
Physically hurt you	__ Never __ Rarely __ Sometimes __ Fairly often __ Frequently
Insulted or talked down to you	__ Never __ Rarely __ Sometimes __ Fairly often __ Frequently
Threatened you with physical harm	__ Never __ Rarely __ Sometimes __ Fairly often __ Frequently
Screamed or cursed at you	__ Never __ Rarely __ Sometimes __ Fairly often __ Frequently
Forced you to have sex	__ Never __ Rarely __ Sometimes __ Fairly often __ Frequently

Review of Systems: Please indicate if you have experienced any of the following within the past year.

System	Symptoms			Additional information
Constitutional	__ Weight loss __ Fever __ Decreased appetite __ Increased thirst	__ Weight gain __ Night sweats __ Fatigue	__ Chills __ Heat intolerance __ Cold intolerance	
Eyes, Ears, Nose, Mouth, Throat	__ Corrective lenses __ Eye irritation __ Loss of hearing __ Vertigo __ Face pressure __ Bleeding gums __ Difficulty swallowing	__ Blind spots __ Double vision __ Ear pain __ Ear pressure __ Sinus congestion __ Snoring/apnea __ Mouth pain	__ Vision change __ Eye pain __ Tinnitus __ Frequent nosebleeds __ Sore throat __ Dental problems	Last dental exam: Provider: Last eye exam: Provider:

Cardiovascular	__ Chest pain __ Cold extremities __ Varicose veins	__ Lightheadedness __ Leg swelling __ Decreased stamina	__ Palpitations __ Heart murmur __ History of rheumatic fever	
Respiratory	__ Cough __ Bloody cough	__ Wheezing __ Asthma	__ Shortness of breath __ Hard to lay flat	
Digestive	__ Abdomen pain __ Constipation __ Tarry stools __ Excess gas	__ Nausea __ Diarrhea __ Bloating __ Mucus in stool	__ Vomiting __ Blood in stool __ Acid reflux __ Parasite infection	
Genitourinary	__ Urine leakage __ Increased frequency __ Slowed urination	__ Incomplete voiding __ Increased urgency __ Waking to urinate	__ Painful urination __ History of stones __ Frequent UTIs	
Muscle and bone	__ Muscle aches __ Back pain __ Difficulty walking	__ Muscle weakness __ Muscle cramping __ History of fracture	__ Joint pain __ Neck pain	
Skin	__ Changing mole __ Wounds __ Jaundice	__ Rash __ Change in hair/nails __ Eczema	__ Skin lesions __ Psoriasis __ Itching	Do you see dermatology? __ Yes __ No Provider:
Neurologic	__ Loss of consciousness __ Migraines __ Change in walking __ Change in memory	__ Numbness/tingling __ Headaches __ History of concussion __ Spasms/twitching	__ Seizures __ Tremor __ Change in speech	
Psychiatric	__ Depression __ Hallucinations __ Panic attacks __ Eating disorder	__ Insomnia __ Suicidal thoughts __ PTSD	__ Anxiety __ Mood swings __ Paranoia	Do you see a counselor? __ Yes __ No Provider:
Blood, Lymph, Immune	__ Swollen glands __ Anemia __ Allergies __ Frequent infection	__ Bruising __ Clotting problems __ Lymph node swelling	__ Easy bleeding __ History of transfusion __ Frequent illness	
Reproductive	__ Decreased libido __ Infertility __ History of hernia __ Irregular menses __ Spotting __ Heavy menses __ Vaginal pain __ Hot flashes	__ Severe cramping __ Vaginal lesion __ Itching/burning __ Abnormal discharge __ Abnormal odor __ Vaginal dryness __ Pelvic pain __ History abnormal PAP	__ Testicular pain __ Testicular mass __ Penile pain __ Penile discharge __ Penile lesion __ Erectile dysfunction	
Mammary	__ Chest mass __ Chest skin changes	__ Chest pain __ Nipple discharge	__ Chest dimpling	

Oral Health Risk Screening

This tool was developed by the American Academy of Pediatrics to aid in assessing oral health risk. It is intended to help document risk factors for ca

Risk Factors	Protective Factors
Primary caregiver had active tooth decay in the past 12 months __ Yes __ No	Existing dental home __ Yes __ No
Primary caregiver does not have a dentist __ Yes __ No	Drinks fluoridated water or takes fluoride tablets __ Yes __ No
Continued use of bottle or sippy cup for fluids other than water __ Yes __ No	Fluoride varnish in the past 12 months __ Yes __ No
Frequent snacking __ Yes __ No	Brushes twice daily __ Yes __ No
Special health care needs __ Yes __ No	
Medicaid eligible __ Yes __ No	

Depression Screening

	Not at all	Several days	More than half the days	Nearly every day
Feeling down, depressed or hopeless				
Little interest or pleasure in doing things				
Trouble falling asleep, staying asleep, or sleeping too much				
Poor appetite, weight loss, or overeating				
Feeling tired or having little energy				
Feeling bad about yourself, or feeling that you are a failure, or that you have let yourself or your family down				
Trouble concentrating on things like school work, reading, or watching TV				
Moving or speaking so slowly other people have noticed or being more fidgety or restless than usual				
Thoughts that you would be better off dead or of hurting yourself in some way				
In the past year, have you felt depressed or sad most days, even if you felt ok sometimes?			Yes	No
How difficult have these problems made it for you to do your work, take care of things at home, or get along with people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
Has there been a time in the past month when you have had serious thoughts about ending your life?			Yes	No
Have you ever, in your whole life, tried to kill yourself or made a suicide attempt?			Yes	N

GAD-7	
Over the last two weeks, how often have you been bothered by the following problems?	
Feeling nervous, anxious, or on edge	__ Not at all __ Several days __ More than half the days __ Nearly every day
Not being able to stop or control worrying	__ Not at all __ Several days __ More than half the days __ Nearly every day
Worrying too much about different things	__ Not at all __ Several days __ More than half the days __ Nearly every day
Trouble relaxing	__ Not at all __ Several days __ More than half the days __ Nearly every day
Being so restless that it is hard to sit still	__ Not at all __ Several days __ More than half the days __ Nearly every day
Becoming easily annoyed or irritable	__ Not at all __ Several days __ More than half the days __ Nearly every day
Feeling afraid as if something awful might happen	__ Not at all __ Several days __ More than half the days __ Nearly every day

Mood Disorder Questionnaire			
Has there ever been a period of time when you were not your usual self and:			
You felt so good or hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	Yes No	You were so irritable that you shouted at people or started fights or arguments?	Yes No
You felt much more self-confident than usual?	Yes No	You got much less sleep than usual and found you didn't really miss it?	Yes No

You were much more talkative or spoke faster than usual?	Yes No	Thoughts raced through your head or you couldn't slow your mind down?	Yes No
You were so easily distracted by things around you that you had trouble concentrating or staying on track?	Yes No	You had much more energy than usual?	Yes No
You were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	Yes No	You were much more interested in sex than usual?	Yes No
You did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	Yes No	Spending money got you or your family in trouble?	Yes No
If you checked YES to more than one of the above, have several of these ever happened during the same period of time?			Yes No
How much of a problem did any of these cause you - like being able to work; having family, money, or legal troubles; getting into arguments or fights? No problem Minor problem Moderate problem Serious problem			
Have any of your blood relatives had manic-depressive illness or bipolar disorder?			Yes No
Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?			Yes No