ADOLESCENT PATIENT INTAKE
Ages 11-17

Patient Information

TODAY'S DATE: _____

Legal name: Last _____ First _____ MI _____ Preferred Name _____

Birthdate _____ Legal sex _____ Gender _____ Pronouns: _____

Parent/Guardian name(s): _____

Primary care provider _____ PCP phone # _____

Preferred pharmacy and location: _____

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

_____

_____

_____

_____

Allergies, medications, & supplements

Allergies	**Allergen**	**Reaction**	**Severity**	**Age**
☐ Epi pen?	_____	_____	_____	_____
☐ No known allergies	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

Medications & Supplements	**Name**	**Dose**	**Frequency**
	_____	_____	_____
☐ None	_____	_____	_____
☐ See attached	_____	_____	_____
	_____	_____	_____

Medical History

Immunization	Date	Immunization	Date
Measles/Mumps/Rubella		DTaP/TDaP	
Varicella/chicken pox		Influenza	
Tetanus (alone)		Smallpox	
Hepatitis A/B (please indicate which received)		Polio/IPV	
Rotavirus		Haemophilus influenzae	
Pneumococcal		HPV	
COVID19		Other	

Please indicate any adverse reactions to vaccines received: _____

Major illnesses:	Date	Diagnostic testing/Hospitalizations	Date
Measles		EEG	
Mumps		Psychological evaluation	
Rubella		Hearing testing	
Chicken pox		Speech/language testing	
Rheumatic fever		Vision exam	
Pneumonia		Other:	
Frequent colds		Other:	
Strep throat		Other:	
Ear infections		Other:	
Tonsillitis		Other:	
Other:		Other:	

Family Health History

Condition	Family member(s)	Condition	Family member(s)
Heart disease		Diabetes	
Birth defects		Hypertension	
Arthritis		Tuberculosis	
Cancer (type)		Allergies	
Asthma		Osteoporosis	
Mental illness		Other:	

Social History

Living situation: _____ Family members in the home: _____

Do you live in more than one home? _____ Any pets: ◯ YES ◯ NO

Are you in school? If so, grade: _____ School attended: _____

Social activities: _____ How much screen time daily? _____

Exposures: ☐ Tobacco smoke ☐ Lead ☐ Fuel burning appliances ☐ Radon

☐ Other: _____

Safety screening: ☐ Wears sunscreen ☐ Smoke/carbon monoxide detectors in the home

☐ Wears helmets ☐ Seatbelt use in cars ☐ Guns in the home ☐ Domestic violence in the home

Typical diet: Please list examples of the foods/drinks regularly consumed.

Breakfast**:** _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

Substance use screening:

☐ Uses tobacco products. Type: _____ Age started: _____

☐ Uses alcohol How much? _____ Age started: _____

☐ Uses drugs Type: _____ Age started: _____

Sexual activity:

Have you ever been sexually active? ◯YES ◯NO Are you currently? ◯YES ◯NO

Do you use any birth control? ◯YES ◯NO If yes, what type: _____

If sexually active, do you use barriers (condoms, dental dams, gloves)? ◯YES ◯NO

Would you like us to identify you as any of the following?

☐Straight/heterosexual ☐Gay/lesbian ☐Bisexual ☐Something else? _____

Have you ever been the victim of sexual or physical violence? ◯YES ◯NO

Do you want to talk about it? ◯YES ◯NO

Do you have any questions about puberty or sexual health today? ◯YES ◯NO

Would you like STI testing today? ◯YES ◯NO

Review of Systems

Please indicate if current (C) or past (P) problems

_____ Jaundice
_____ Hives
_____ Eczema
_____ Rashes
_____ Allergic reaction
_____ Bad breath
_____ Body odor
_____ Acne
_____ Hair loss
_____ Burning urine
_____ Bloody urine
_____ Other: _____

_____ Easy bruising
_____ Vomiting spells
_____ High fevers
_____ Dizzy spells
_____ Sore throat
_____ Headache
_____ Nose bleeds
_____ Constipation
_____ Diarrhea
_____ Stomach ache
_____ Poor appetite
_____ Other: _____

_____ Joint pain
_____ Fatigue
_____ Coughing
_____ Wheezing
_____ Heart murmur
_____ Light sensitivity
_____ Bedwetting
_____ Night sweats
_____ Nervousness
_____ Unusual fears
_____ Cries easily
_____ Other: _____