

Adolescent History Sheet

Patient Name: _____

Birth Date: _____ Age: _____ Male Female

Family	Name	Age	Education	Occupation	Health	Ht	Wt
Father	_____	_____	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____	_____	_____
Brothers	_____	_____	_____	_____	_____	_____	_____
Sisters	_____	_____	_____	_____	_____	_____	_____
Others Living in Household	_____	_____	_____	_____	_____	_____	_____

Family Intact? _____ Patient Lives With: _____

School: _____ Grade Level: _____

<p>Do you want to discuss a health problem or injury? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>HAS ANYONE IN YOUR FAMILY EVER HAD:</p> <p>Diabetes (high sugar in blood)? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Allergies (hay fever or asthma)? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Migraine headaches? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Heart Trouble? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>High Blood Pressure? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Has anyone in your family under age 50 died suddenly? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>HAVE YOU HAD OR DO YOU NOW HAVE:</p> <p>Brain Concussion (head injury)? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Tendency to Lose Consciousness (faint)? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Skull Fracture? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Convulsions or Epilepsy? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Neck Injury? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Very Bad (impaired) Vision in One Eye? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Temporary Loss of Vision? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Wear Glasses or Contacts? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Hearing Loss? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Perforated Ear Drum? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Discharge From Ear (recurrent infection)? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Sinus Infection? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Broken Nose? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Hernia? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Kidney Problems? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Bone Fracture? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Joint Dislocation? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Boys: Loss of Function or Absence of Testicles? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Girls: Menstrual Problems? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Age of Onset of Menstruation _____</p>	<p>HAVE YOU HAD OR DO YOU HAVE NOW:</p> <p>Back Injury or Frequent Backaches? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Knee Injury (sprain) or Recurrent Pain? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Ankle Injury (sprain) or Recurrent Pain? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Other Joint Trouble? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Bone Infection? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Diabetes (high sugar in blood/urine)? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Tendency to Bleed or Bruise Easily? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Anemia (tired blood)? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Hay Fever? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Hives or Rash? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Bee Sting Reactions (allergy)? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Reaction to Medicine (allergy)? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>DO YOU:</p> <p>Smoke? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Take Any Medicine Regularly? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If yes, please list: _____</p> <p>Take Medicine for Emergency Use? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If yes, please list: _____</p> <p>HAVE YOU HAD OR DO YOU HAVE NOW:</p> <p>Heart Trouble or Murmur? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>High Blood Pressure? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Persistent Cough? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Chest Pain with Exercise? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Dizziness or Faintness with Exercise? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Recurrent Rash? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Fungus Infection? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Athlete's Foot? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Recurrent Boils (skin infection)? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you wish to discuss an emotional problem with your doctor? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Have you ever been told to give up sports because of health problems? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>
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