Associates in Family Medicine

Patient History Form (Adolescent to age 18)

Patient Name_____ DOB_____ Today's Date_____

Mother's name_____ Father's name_____

Home phone_____ Alternate phone_____

Who lives in your household?_____

Are they in good health?_____

MEDICAL HISTORY

Please list any current or past illnesses you have been treated for:

_____

_____

_____

Please list any medications you are currently taking. Please include strength and frequency.

Medication	**Strength (mg.)**	**Frequency**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any medication allergies? Yes No
Please list name of drug and type of reaction:

_____

Do you have a latex allergy? Yes No

Please list surgical procedures you have had in the past:

_____

Job/Employment: _____

(CONTINUED)

Do you currently or have you ever done the following (check all that apply):

____Smoke cigarettes or pipe. If yes, how many per day?_____
____Use smokeless tobacco. If yes, how many times per day?_____
____Vaping: ____with nicotine ____without nicotine
____Drink alcohol. If yes, how many drinks per day?_____
____Use recreational drugs or prescription drugs prescribed for someone else? If yes, how many times per week and what type?_____
____ Does anyone in the household: ___smoke ___drink alcohol ___use recreational drugs
____Exercise regularly? If yes, how many times per week?_____
____Wear seat belts regularly.
____Wear safety helmets.
____Sexually active. If yes: ___Bisexual ___Same sex ___Heterosexual
____ Practice safe sex. If yes, what type of birth control do you use?_____

Please list all physicians you have seen in the past 5 years:

_____ _____ _____

IMMUNIZATION HISTORY:

Are immunizations up-to-date? Yes No
Has your child ever had a serious reaction to an immunization? Yes No (If yes, explain in space below)
Do you have immunization records? Yes No (If so, please have them sent to us or bring them to the appointment)

Do you have problems with (check all that apply):

____Difficulty with vision	____Problems with teeth	____Constipation	___Dizziness
____Crossed eyes	____Shortness of breath	____Bowel habit change	___Overly anxious
____Eye infections	____Frequent cough	____Rectal bleeding	___Weight gain
____Difficulty hearing	____Wheezing	____Abdominal pain	___Weight loss
____Frequent ear infections	____Swelling	____Bed wetting	___Fatigue
____Frequent colds	____Fainting	____Headaches	___ Cry easily
____Frequent sore throats	____Heart racing	____Seizures	___Bullying
____Mouth breathing	____Nausea/vomiting	____Joint pain	___Often depressed
____Snoring	____Diarrhea	____Muscle pain or cramps	___Sexual concerns
____Hoarseness	____Rashes/hives	____Muscle weakness	___Learning disability
____Difficulty swallowing	____Blood in urine	____Excessive thirst	___Hyperactivity
____Birth defects	____Heart murmur	____Menstrual periods	

FEMALES ONLY:

Last menstrual period_____ Have you ever had a pap smear? _____

Have you ever been pregnant? ___No ___Yes If yes:

Do you have any concerns? _____

MALES ONLY:

Do you have any concerns?_____

(CONTINUED)

FAMILY HISTORY:

Please place a check mark if any family members have had the following medical problems. Please write in space below if additional room is needed:

FAMILY HEALTH HISTORY

(Please check the box where child's BLOOD relatives have any of these problems)

	FATHER	MOTHER	Grandfather		Grandmother		BROTHER	SISTER	MOTHER'S SIDE	FATHER'S SIDE
			Maternal	Paternal	Maternal	Paternal				
Allergies (asthma, exzema, hay fever)										
Birth defects (cleft lip, Down's syndrome)										
Blood/ bleeding disorders, sickle cell anemia										
Bone/joint disorders (arthritis, hip disorders)										
Cancer (leukemia, breast cancer, other tumors)										
Diabetes, thyroid disorders										
Eye/ear disorders (deafness, blindness)										
Heart disease (heart attack, high blood pressure)										
Kidney disease (cystic kidneys, absent kidney)										
Lung disorders (cystic fibrosis, tuberculosis)										
Muscle disorders (Multiple Sclerosis, Muscular Distrophy)										
Neurologic disorders (migraine headaches, seizures, epilepsy)										
Psychiatric disorders (suicide, depression, anxiety)										
Sexually transmitted diseases (syphilis, gonor-rhea, herpes, chlamydia)										
Alcoholism, drug dependency, HIV/AIDS										
Other										

The following information is of value in the complete evaluation of your child. Answering is optional and confidential.

School: ___Cyber ___Private ___Public Daycare: ___Home ___Elsewhere

PLEASE CIRCLE LEVEL OF EDUCATION:

	High School	Vocational School	College	Graduate School
Mother……	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4
Father ……	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4

Thank you for choosing Associates in Family Medicine and completing this important health history form. This information will help your doctor provide the best care for you.

2/2016