PATIENT HISTORY – TEENAGERS

In an effort to serve you better, we request that you provide us with the following information. We need this information to give you the best care and treatment possible. All information is held strictly confidential and is released only with your written consent.

Medical Record # **Date:**

Last Name		**First Name**		**Middle Initial**
Date of Birth	**Age**	**Sex:** **Male** **Female**	**Primary Care Physician**	

Allergies: None ☐		**Medications:** None ☐	
Please list allergies and type of reaction (please include medication, environmental and food allergies)		Please list all medications you take and the dosages (including over the counter medications)	
Item	Reaction	Medication and Strength	Dosage

Immunizations:	Yes	No
Was your last tetanus shot more than 10 years ago?	☐	☐
Have you had a Varicella (Chickenpox) booster?	☐	☐
Have you had a MMR booster shot?	☐	☐
Other Questions:	Yes	No
Are you pregnant or trying to become pregnant? Last Menstrual Period _____________	☐	☐

Family History:	**Yes**	**No**	**Relationship**
Cancer	☐	☐	____________
Heart Disease	☐	☐	____________
Stroke	☐	☐	____________
Diabetes	☐	☐	____________
Other _____________	☐	☐	____________

Illness/ Injury – Please check if you have ever had:

	Yes	**No**		**Yes**	**No**
Asthma	☐	☐	Gallstone (GI)	☐	☐
Broken Bones (Fractures): ________	☐	☐	Heart Attack (Cardio)	☐	☐
Chickenpox	☐	☐	Hepatitis (Infect)	☐	☐
Diabetes	☐	☐	High Blood Pressure (Cardio)	☐	☐
History of Heart Murmur	☐	☐	Kidney Stones (GU)		
---			Lung Problems (Pulmonary)	☐	☐
Anxiety/Depression (Psych)	☐	☐	Peptic Ulcer (GI)	☐	☐
Blood Transfusion (Hematology)	☐	☐	Rectal Bleeding (GI)	☐	☐
Cancer (Neoplastic)	☐	☐	Stroke (Neuro)	☐	☐
Chest Pain/Tightness (Cardio)	☐	☐	Thyroid Problems (Metabolic)	☐	☐
Diverticulitis (GI)	☐	☐	Yellow Jaundice (Hematology)	☐	☐
ADD/ ADHD	☐	☐			

Surgery or Hospitalizations: List the date and type of operations you have had.

Year	Operation or Reason for Hospitalization

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SENTARA
RMH Medical Center

SPECIAL NOTICE TO PARENTS

Over half of all teenagers are sexually active, and a large number smoke, experiment with alcohol and drugs, and experience abuse of one kind or another. Teenagers also tend to get depressed easily, and are one of the highest suicide risk groups in the U.S.

As a preventative medicine measure, we would like for your son or daughter to fill out a questionnaire addressing these issues. The information is confidential, and can not be shared with parents unless your child agrees to do so. Our counseling will address these issues with emphasis on abstinence and recommendations to share concerns with parents.

Patient Name: ___________________________ Date of Birth: ______________________

CONSENT: I agree to allow my son or daughter to fill out the following information in private. I also realize this information and any treatments or medicines (i.e. birth control) is confidential and cannot be shared with me unless my child grants such permission.

Parent Name Printed: __________________________________

Parent Signature: ______________________________________ Date: ________________

To be completed by patient:

Nutrition:	Yes	No
1. Have you experience unexpected weight gain or loss over the past several months?	☐	☐
2. Do you ever eat in secret?	☐	☐
3. Are you unhappy or concerned about your eating patterns?	☐	☐
4. Do you have a weight problem that you would like treated?	☐	☐
5. Do you drink 3 glasses of milk per day?	☐	☐
Confidential Information :		
1. Do you, or have you ever smoked or chewed tobacco/snuff?	☐	☐
Are you a current smoker? ☐ Yes ☐ No		
Frequency of Smoking:		
☐ Every day smoker ☐ Smoker, Unknown frequency ☐ Some day smoker		
☐ Former Smoker ☐ Unknown if ever smoked		
2. Do you drink alcohol?	☐	☐
Have you ever felt the need to cut down on your drinking?	☐	☐
Have you ever felt annoyed by others criticizing you drinking habits?	☐	☐
Have you ever felt guilty about your drinking?	☐	☐
Do you ever take a drink first thing in the morning?	☐	☐
3. Do you, or have you ever taken drugs (marijuana, cocaine, etc)?	☐	☐
4. Do you feel you experience anxious, depressed, or other emotional concerns?	☐	☐
5. Have you ever felt like committing suicide or harming others?	☐	☐
6. Have you ever been sexually or physically abused?	☐	☐
7. Have you ever been sexually active with a member of the same or opposite sex?	☐	☐
8. Have you had more than one sexual partner in the past year?	☐	☐
9. Are you interested in birth control?	☐	☐
10. Have you ever had a sexually transmitted disease (gonorrhea, syphilis, Chlamydia, genital warts, AIDS, etc)?	☐	☐
11. Are you concerned that you may have AIDS?	☐	☐
12. Would you like an "exercise prescription"?	☐	☐
13. Do you have problems hearing or understanding conversations?	☐	☐

Provider Reviewed: ______________________________ Date: _______________