YOUTH HEALTH & WELLNESS CENTER

K-TOWN YOUTH HEALTH CENTER

ADOLESCENT PERSONAL & FAMILY HEALTH HISTORY (18 years or older)

Patient Name: _____

Date of Birth: _____

Patient #: _____

1. Are you healthy today? □ Yes □ No

Please tell us any concerns you have: _____

_____

2. Are you allergic to any medicine? □ Yes □ No

If yes, what drug(s)? _____

What happens? _____

3. List any medication you are taking now and the problem for which the medication was given:

Medication	Dosage	Reason	How long?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

4. Have you ever been hospitalized or had surgery? □ Yes □ No

If yes, please explain below:

Date _____ Problem / Surgery _____

Date _____ Problem / Surgery _____

5. Have you ever had any serious or sports-related injuries? □ Yes □ No

If yes, explain _____

6. Has there been any change in your health during the past year? □ Yes □ No

If yes, explain _____

7. Please check (√) whether you have ever had any of the following health problems. If yes, at what age did the problem start?

	Yes	No	Age		Yes	No	Age
ADD / ADHD				Depression or Anxiety			
Anemia or blood disorders				Kidney / urinary problems			
Asthma				Mononucleosis			
Cancer / Leukemia				Scoliosis			
Diabetes				Seizures			
Heart murmur / heart problems				Guillan-Barre syndrome			
Immune disorders, HIV / AIDS				Concussion / head injury			
Headaches / Migraines				Liver Disease			
Stomach or bowel problems				Vision / hearing / speech problems			
				Learning disability, special education needs			

Patient Name: _____

Date of Birth: _____

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Please explain any yes answers: _____

_____

_____

_____

Family and Social History

8. Have you or any of your blood relatives (parents, grandparents, aunts, uncles, brothers or sisters), living or deceased, had any of the following problems? If the answer is Yes, please state the age of the person when the problem occurred and their relationship to you.

	Yes	No	Unsure	Age at onset	Relationship
Alcoholism / Drugs					
Allergies / Asthma					
Blood Disorders					
Cancer - type:					
Diabetes					
Heart attack or stroke					
High blood pressure					
High cholesterol					
Mental health / Depression					
Smoking					
Other - specify:					

9. Who do you live with most of the time? (Check all that apply)

□ Both parents in the same household □ Mother □ Father □ Step Mother □ Step Father

□ Guardian □ Brother(s) / ages _____ □ Sister(s) / ages _____

□ Other _____

10. **In the past year**, have there been any changes in your family such as:

□ Marriage □ Serious illness □ Change in school □ Separation □ Loss of job

□ Births □ Divorce □ Move to a new house □ Deaths □ Incarcerations

□ Other _____

Patient Signature _____ Date _____

Provider Signature _____ Date reviewed _____