YOUTH HEALTH & WELLNESS CENTER

K-TOWN YOUTH HEALTH CENTER

ADOLESCENT PERSONAL & FAMILY HEALTH HISTORY (< 18 years)

Patient Name: _____

Date of Birth: _____

Patient #: _____

1. Do you feel your adolescence is healthy today? □ Yes □ No

Please tell us any concerns you have: _____

2. Is your adolescent allergic to any medicine? □ Yes □ No

If yes, what drug(s)? _____

What happens? _____

3. List any medication your adolescent is taking now and the problem for which the medication was given:

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

4. Has your adolescent ever been hospitalized or had surgery? □ Yes □ No

If yes, please explain below:

Date _____ Problem / Surgery _____

Date _____ Problem / Surgery _____

5. Has your adolescent ever had any serious or sports-related injuries? □ Yes □ No

If yes, explain _____

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

If yes, explain _____

_____

7. Please check (√) whether your adolescent 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			

Please explain any yes answers: _____

_____

_____

_____

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8. Regarding Immunizations: the following questions will help us determine if it is safe for your adolescent to receive vaccines.

	Yes	No	Please Explain
Allergy to medication, eggs, food, latex, vaccine components			
Has the adolescent had serious reaction to a vaccination, including the flu or flu mist			
Health problem with lung, heart, kidney, or metabolic disease, asthma, neurologic or neuromuscular disease, liver disease, anemia, or blood disorder			
Has the adolescent, sibling, or a parent had a seizure; have they had a brain or other nervous system problems			
Use of cortisone, prednisone or other steroids, anti-cancer drugs or radiation treatment in the last 3 months			
Has the adolescent ever had Guillain-Barre syndrome			
Does the adolescent have cancer, leukemia, HIV/AIDS, or other immune system problem			
Has your adolescent received vaccines in the last 4 weeks			
Blood Transfusions, IgG or antiviral medication in the past year			
Is your child on aspirin therapy			
Is the adolescent pregnant or may become pregnant			

Family and Social History

9. Have you or any of your adolescent's 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 your teen.

	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:					

10. With whom does the adolescent live 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 _____

11. **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 _____

Parent/Guardian Signature _____Date reviewed_____

Provider Signature _____ Date reviewed _____