NOVI INTERNAL MEDICINE AND PEDIATRICS, PLLC

Adolescent Health History Questionnaire - 13-17 Years

DOS_____ Last Name _____ First Name _____ DOB_____

ADOLESCENT INFORMATION

Why did you come to the clinic today?_____

_____

Sex: ☐ Male ☐ Female Age _____ Grade in School _____ Year in college_____

Language(s) spoken in your home: _____

ADOLESCENT MEDICAL HISTORY

Are you allergic to any medicines? ☐ Yes ☐ No Name of medicine_____

Are you taking any medicine now? ☐ Yes ☐ No Name of medicine_____

Do you have any health problems? ☐ Yes ☐ No Problem_____

Have you ever been hospitalized overnight? ☐ Yes ☐ No

If yes, give age hospitalized and describe problem Age _____ Problem _____

Age _____ Problem _____

Have you ever had any of the following illnesses or problems? If yes, check all that apply:

☐ Allergies	☐ Endocrine/gland disease	☐ Scoliosis
☐ Anemia or blood disorders	☐ Hepatitis	☐ Seizures
☐ Asthma	☐ Headaches/migraines	☐ Severe acne
☐ Bladder/kidney infections	☐ Mental illness or depression	☐ Sports injuries or broken bones
☐ Cancer	☐ Mononucleosis	☐ Thyroid disease
☐ Chicken pox	☐ Pneumonia	☐ Tuberculosis
☐ Diabetes	☐ Rheumatic fever/heart disease	☐ Ulcer or digestive problems

☐ Other _____

FAMILY HISTORY

Please check (✓) below if any of the adolescent's blood relatives, living or deceased, have ever had any of the following problems? (e.g., Place ✓ in column headed "F" if adolescent's father had asthma) See below for column heading explanations.

O = None F = Father GP = Grandparent

M = Mother S/B = Sister/Brother A/U = Aunt/Uncle

	O	M	F	S/B	GP	A/U		O	M	F	S/B	GP	A/U
Allergies							Endocrine/gland disease						
Arthritis							Heart attack/stroke/ sudden death before age 55						
Asthma							Heart attack/stroke after age 55						
Bleeding disorders/Sickle cell anemia							High blood pressure						
Birth defects							High cholesterol						
Cancer							Kidney disease						
Developmental delay or retardation							Lung disease/ tuberculosis						
Depression/Suicide/ Mental health problems							Seizures						
Diabetes							Substance abuse (alcohol or drug problem)						
Eating disorders							Smoking						
Other (specify)													

Comments _____

_____

Provider Signature _____ Date _____