

Patient's Name: _____
 Birth date: _____ Current age: _____ Gender: _____
 Previous doctor: _____ City & State: _____
 Reason for changing doctors: _____
 Person who is filling out this form: _____ Relation to teen: _____

SOCIAL HISTORY

Who lives in the home with this teenager?

Full Name	Age	Relation to teenager
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are there any pets at home (inside or outside)? No Yes: _____
 Does anyone smoke (inside or outside)? No Yes (who): _____

*We recommend that your teen is **NOT** around any tobacco smoke. Exposure to tobacco smoke or even the smell of smoke can increase your teen's risk for "colds," bronchitis, and asthma.*

What are the parents' occupations?

Mother/partner: _____ Father/Partner: _____

What is the parent's education? Indicate highest level of education:

Mother/partner: _____ Father/Partner: _____

If the parents or the teen was NOT born in the US, which country are you from?

GROWTH

If available, please note your child's length, height, and weight at the following ages:

	2 mos	4 mos	6 mos	9 mos	1 year	18 mos	2 years	3 years	4 years	5 years
Height										
Weight										
Head Circ.										

LAB WORK OR DIAGNOSTIC TESTING

If your child has had any special lab work or diagnostic tests done, please note them (for example, blood tests, x-rays, CT scan, ultrasound, endoscopy, EEG, EKG, etc.)

Date	Place Tests Were Done	Test	Reason	Results

SPECIALISTS OR CLINICS

Does your child see any other specialists or clinics: (Not only physicians, but please include psychologists, counselors, physical, occupational, or speech therapists, Meningomyelocele Clinic, Developmental Assessment Clinic, etc.)

Name	Address	Reason Seen	Date Last Seen

FAMILY MEDICAL HISTORY:

Please note if present in family members (parents, siblings, grandparents, others related by blood):

- | | |
|---|---|
| <input type="checkbox"/> Asthma: _____ | <input type="checkbox"/> Colitis (Crohn’s or ulcerative colitis): _____ |
| <input type="checkbox"/> Allergies: _____ | <input type="checkbox"/> Irritable bowel syndrome: _____ |
| <input type="checkbox"/> Diabetes mellitus: _____ | <input type="checkbox"/> Kidney stones: _____ |
| <input type="checkbox"/> Thyroid problems: _____ | <input type="checkbox"/> Bladder or kidney problems: _____ |
| <input type="checkbox"/> Sickle cell anemia: _____ | <input type="checkbox"/> Cancer: _____ |
| <input type="checkbox"/> Seizures: _____ | <input type="checkbox"/> Heart attack or problems (before 50 years old) : _____ |
| <input type="checkbox"/> Migraines: _____ | _____ |
| <input type="checkbox"/> Depression: _____ | <input type="checkbox"/> High cholesterol: _____ |
| <input type="checkbox"/> Anxiety: _____ | <input type="checkbox"/> Other heart problems: _____ |
| <input type="checkbox"/> Attention deficit/hyperactivity: _____ | <input type="checkbox"/> Other medical problems: _____ |
| <input type="checkbox"/> Alcohol / drug abuse: _____ | _____ |

Cholesterol screen:

Have the teen’s parents or grandparents had any of these problems *when they were younger than 55 years old?*

- heart attack angina stroke hardening of the arteries sudden death from a heart problem
 heart surgery (by-pass or balloon angioplasty) cholesterol level more than 240

PREVIOUS MEDICAL PROBLEMS

Has your teen ever had any of these problems?

- | | |
|--|---|
| <input type="checkbox"/> Problems seeing or hearing: _____ | <input type="checkbox"/> Sickle Cell Anemia: _____ |
| <input type="checkbox"/> Mono: _____ | <input type="checkbox"/> Anemia: _____ |
| <input type="checkbox"/> Strep throat: _____ | <input type="checkbox"/> Pregnancy or caused a pregnancy: _____ |
| <input type="checkbox"/> Nasal allergies: _____ | <input type="checkbox"/> Sexually transmitted diseases: _____ |
| <input type="checkbox"/> Wheezing: _____ | <input type="checkbox"/> Migraines: _____ |
| <input type="checkbox"/> Asthma: _____ | <input type="checkbox"/> Seizures: _____ |
| <input type="checkbox"/> Pneumonia: _____ | <input type="checkbox"/> Head injury: _____ |
| <input type="checkbox"/> Other breathing or respiratory problem: _____ | <input type="checkbox"/> Other neurological problems: _____ |
| _____ | _____ |
| <input type="checkbox"/> Bladder/kidney infection: _____ | <input type="checkbox"/> Any broken bones: _____ |
| <input type="checkbox"/> Other bladder/kidney problem: _____ | <input type="checkbox"/> Any stitches: _____ |
| _____ | <input type="checkbox"/> Any poisoning: _____ |
| <input type="checkbox"/> Any stomach or digestive problems: _____ | <input type="checkbox"/> Any burns that needed a doctor’s care: _____ |
| _____ | <input type="checkbox"/> Attention deficit / hyperactivity: _____ |
| <input type="checkbox"/> Any glandular problems (diabetes, thyroid, etc.): _____ | <input type="checkbox"/> Weight concerns (too much/too little): _____ |
| _____ | <input type="checkbox"/> Alcohol / drug use (<i>ever</i>): _____ |
| <input type="checkbox"/> Heart murmur: _____ | <input type="checkbox"/> Tobacco use (<i>ever</i>): _____ |
| <input type="checkbox"/> Other problems with the heart: _____ | <input type="checkbox"/> Any other conditions: _____ |
| _____ | _____ |

Patient Name: _____ DOB _____

Has your teen ever received counseling for a behavioral problem or concern? No Yes: _____

Has your teen ever had any surgery? No Yes: _____

Has your teen ever been in the Emergency Room? No Yes: _____

Has your teen ever stayed overnight in the hospital (except at birth)? No Yes: _____

Has your teen taken any medications in the last 2 weeks?

Medication	Dosage	Reason for medication	When started

Has your teen ever had an allergic reaction to medications? No Yes

What medication & what kind of reaction: _____

PUBERTAL DEVELOPMENT

Female:

Have you started your periods (menses)? Yes No

How old were you when your periods started? _____

How often does your period come? _____

How many days do you have your period (bleeding)? _____

Do you have any cramps with your period? Yes No

Do you take any medications for cramps? Yes No If yes, what: _____

Do you examine your breasts every month? Yes No

Male:

Has your voice changed? No Yes How old were you when you first noticed this? _____

Are you growing facial hair? No Yes How old were you when you first noticed this? _____

Have your testicles enlarged? No Yes How old were you when you first noticed this? _____

Have you had any "wet dreams"? No Yes

Do you do a testicular exam at home? No Yes

Do you have any concerns about your testicular exam? No Yes: _____

Does your teen have any of these symptoms now? None

- | | | | |
|--------------------------------------|--|---|---|
| <input type="checkbox"/> fever | <input type="checkbox"/> wheeze | <input type="checkbox"/> constipation | <input type="checkbox"/> pain with urination |
| <input type="checkbox"/> headache | <input type="checkbox"/> feeling short of breath | <input type="checkbox"/> rash | <input type="checkbox"/> limping |
| <input type="checkbox"/> runny nose | <input type="checkbox"/> chest pain | <input type="checkbox"/> fatigue | <input type="checkbox"/> joint or muscle pain |
| <input type="checkbox"/> stuffy nose | <input type="checkbox"/> stomach ache | <input type="checkbox"/> looks pale | <input type="checkbox"/> joint swelling |
| <input type="checkbox"/> ear pain | <input type="checkbox"/> nausea | <input type="checkbox"/> acne | <input type="checkbox"/> loss of balance |
| <input type="checkbox"/> sore throat | <input type="checkbox"/> vomiting | <input type="checkbox"/> behavior changes | |
| <input type="checkbox"/> cough | <input type="checkbox"/> diarrhea | <input type="checkbox"/> urinating more often | |

Tuberculosis screen: Yes to any of these questions No to all of these questions

Has your teen:

- had any contact with any one who has confirmed or suspected infectious tuberculosis?
- had any contact with anyone who has been at Camp Highfield, the Ingham County Youth Center, or detained in a law-enforcement facility (such as a jail or prison) within the last 5 years?
- visited any countries for more than 3 weeks?
Asia, Middle East, Africa, Latin or South America, Eastern Europe
- had daily contact for more than 3 weeks with any of the following individuals: HIV infected; homeless; residents of nursing homes or institutions; users of illicit drugs; migrant farm workers; foster children with exposure to adults in the above high-risk groups?
- had daily contact for more than 3 weeks with people who have traveled to or lived in countries in these areas?
Asia, Middle East, Africa, Latin or South America, Eastern Europe

Does your teen have parents who have lived in any countries from these areas? *Asia, Middle East, Africa, Latin America, Eastern Europe*

DEVELOPMENT

Please describe your teen’s school progress:

Current grade level _____ Current school: _____

Ever repeated a grade? No Yes: _____ Ever advanced a grade? No Yes: _____

Has your teen had any difficulties in school (either socially or academically): No Yes: _____

What kind of grades or evaluation does your teen usually get? Excellent Good OK So-so Poor

Any recent changes in grades either upwards or downwards? No Yes: _____

How does your teen feel about their grades? Very pleased Satisfied Unsatisfied

How do you feel about your teen’s grades? Very pleased Satisfied Unsatisfied

Do you have any concerns about your teen’s school progress? No Yes: _____

SOCIAL LIFE

What kind of hobbies, extra-curricular activities, or sports does your teen participate in? _____

What does your teen want to be when she/he grows up? _____

What kind of future plans does you teen have as far as college or vocational training? _____

Does you teen have a job? No Yes Where: _____ How many hours/week _____

Does your teen have a driver’s license? No Yes

Does your teen operate farm equipment? No Yes: _____

Does your teen ride an RV (recreational vehicle)? No Yes: _____

Is there anything else you would like us to know about your teenager?

Teenager Signature: _____

Date: _____

Parent Signature: _____

Date: _____

Physician Signature: _____

Date: _____