# Adolescent Medicine & Student Health Services
# Health History Questionnaire

Patient Name: _____ Date of Birth: _____

## Patient's Health History

Are immunizations up to date? ☐ Yes ☐ No

Date of Last Exam: _____ Previous Doctor: _____ Phone #_____

List all medications that the patient is currently taking (include medicines such as prescribed drugs, over-the-counter, vitamins, birth control and inhalers): _____

| Does the **PATIENT** have or ever had any of the following: | **Yes** | **No** | **Explain** |
|---|---|---|---|
| A serious medical condition / problem? | | | |
| Been hospitalized or had surgery? | | | |
| A serious injury or accident? | | | |
| Chicken pox? When? _____ | | | |
| Allergies, asthma, bronchitis, respiratory infections? | | | |
| Repeated ear infections, tubes, difficulty with hearing? | | | |
| Problems with eyes or vision? | | | |
| Heart problems or a heart murmur? | | | |
| Anemia, bleeding problems, blood transfusion, or clotting disorder? | | | |
| Abdominal pain, constipation requiring doctor visits? | | | |
| Recurrent vomiting, recurrent diarrhea, blood in stools? | | | |
| Bladder or kidney infections, bed wetting after 5 yrs.? | | | |
| Recurrent skin problems (acne, eczema, etc.)? | | | |
| Headaches, convulsion, other neurologic problems? | | | |
| Mental health concerns (ADHD, depression, anxiety)? | | | |
| Diabetes, thyroid, or other endocrine problems? | | | |
| If female, have menstrual periods started? If YES, LMP ____/____/____ Any problems? | | | |

## Development

| **Are you concerned about the patient's:** | **Yes** | **No** | **Explain** |
|---|---|---|---|
| 1. Physical development? | | | |
| 2. Mental or emotional development? | | | |
| 3. Learning ability? | | | |
| 4. Attention span or activity level? | | | |
| **If in school, has the patient had:** | | | |
| 1. Tutoring outside of the classroom? | | | |
| 2. Placement in a special or resource class? | | | |
| 3. To repeat a grade? | | | |
| 4. Educational or psychological testing? | | | |
| 5. Behavioral problems? | | | |

# Adolescent Medicine & Student Health Services
# Health History Questionnaire

## Family Health History

If a family member has had any of the following problems, check the appropriate box for the family member. Please notate if the family member is living or deceased.

| Diagnosis | Mother ☐ Living ☐ Deceased | Father ☐ Living ☐ Deceased | Sister ☐ Living ☐ Deceased | Brother ☐ Living ☐ Deceased | Maternal Gmother ☐ Living ☐ Deceased | Maternal Gfather ☐ Living ☐ Deceased | Paternal Gmother ☐ Living ☐ Deceased | Paternal Gfather ☐ Living ☐ Deceased |
|---|---|---|---|---|---|---|---|---|
| ADD / ADHD | | | | | | | | |
| Allergies | | | | | | | | |
| Anxiety | | | | | | | | |
| Asthma | | | | | | | | |
| Autism (ASD) | | | | | | | | |
| Bipolar Disorder | | | | | | | | |
| Blood Disorders; Bleeding / Clotting | | | | | | | | |
| Cancer | | | | | | | | |
| Celiac Disease | | | | | | | | |
| Colitis / Ulcerative Colitis / Crohn's | | | | | | | | |
| Coronary Artery / Heart Disease | | | | | | | | |
| Deafness | | | | | | | | |
| Depression | | | | | | | | |
| Development Delay | | | | | | | | |
| Diabetes | | | | | | | | |
| Eczema | | | | | | | | |
| Genetic Disorder | | | | | | | | |
| Hypertension | | | | | | | | |
| Learning Disability | | | | | | | | |
| Migraines | | | | | | | | |
| Obesity | | | | | | | | |
| Schizophrenia | | | | | | | | |
| Seizure Disorder | | | | | | | | |
| Substance Abuse (Drug / Alcohol) | | | | | | | | |
| Thyroid Disease | | | | | | | | |
| Other: | | | | | | | | |

## Social History / Relationships

Who does the patient live with? ☐ Mother ☐ Both Parents ☐ Group Home: _____
☐ Father ☐ Foster Parent ☐ Other: _____

Who lives in the home with the patient? _____

Is there Social Services (DSS) involvement? ☐ Yes ☐ No If Yes, please explain and provide documentation.

_____

CARILION Children's

PATIENT IDENTIFICATION