
Name

Adolescent Medical History: Parent/Guardian Forms
PLEASE COMPLETE BOTH (2) PAGES

DO YOU HAVE ANY CONCERNS ABOUT YOUR ADOLESCENT'S HEALTH OR BODY? _____

PLEASE LIST ALL MEDICATIONS, VITAMINS, HERBS AND SUPPLEMENTS HE/SHE IS TAKING:

Name Dose (for example mg/pill) How many times per day When started

ALLERGIES/REACTIONS TO MEDICINES or VACCINES: _____

PREVENTIVE CARE: When were his/her most recent:

Hepatitis A shot _____ Hepatitis B shot _____ Influenza (flu shot) _____ Measles shot _____

Pneumovax shot _____ Rubella shot _____ Tetanus (Td) shot _____

Varicella (chicken pox) shot or illness _____ PPD (Tuberculosis skin test) _____ Dental Exam _____

PERSONAL MEDICAL HISTORY: Please list any major medical problems and their dates.

Hospitalizations/Operations (with dates): _____

Broken bones or severe injuries (with dates): _____

In the past year have there been any changes in your family? (Check all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Marriage | <input type="checkbox"/> Loss of job | <input type="checkbox"/> Birth |
| <input type="checkbox"/> Separation | <input type="checkbox"/> Move to new neighborhood | <input type="checkbox"/> Serious illness |
| <input type="checkbox"/> Divorce | <input type="checkbox"/> Change to new school | <input type="checkbox"/> Death |
| <input type="checkbox"/> Other changes/stresses | | |

SCHOOL HISTORY: Current grade _____ Name of school _____

Do you have any concerns about your performance in school? _____ Do your parents? _____ Do your teachers? _____

What do you want to do or be after you complete school? _____

EXERCISE: What sports or exercise do you do? _____ Days per wk? _____ Minutes each time? _____
How many minutes per day do you watch TV or use a computer? _____

INJURY PREVENTION;

- Does anyone in the home smoke cigarettes or use other tobacco products? Yes No
- Do you wear sunscreen when in the sun? Yes No
- Are you frequently exposed to loud noises, such as concerts, earphones or machinery? Yes No
- Do you wear a seatbelt when riding in a car, truck or van? Yes No
- Do you wear a helmet when skateboarding, rollerblading, or riding a bicycle or scooter? Yes No
- Do you ride a motorcycle, hang glide, or fly an airplane? Yes No
- Does your home have smoke detectors? Yes No
- Is there a gun in your home? Yes No
- If so, is it kept unloaded and locked out of reach? Yes No
- Do students in your school carry guns or knives to school? Yes No
- Are you worried about violence or your safety? Yes No
- Have you ever been in trouble with the police? Yes No

- DIET:** Do you eat 5 servings of fruits and vegetables every day? Yes No
- Do you drink 4 glasses of milk (1 quart) daily or get calcium from other sources? Yes No
- Are you happy with your current weight? Yes No
- Do you follow a special diet? Yes No If so, please describe: _____
- Have you ever done any of the following to loose weight:
- Skipped meals, taken pills, or other medications, caused vomiting or used laxatives? Yes No
- Caffeine intake: None Coffee/tea _____ cups/day Soda _____ cans/day Chocolate _____ oz/day

SUBSTANCE USE:

- Have you ever tried smoking cigarettes? Yes No If so, when was the last time? _____
- Do you smoke cigarettes regularly? Yes No If so, how many cigarettes each day? _____
- At what age did you start? _____ Are you interested in quitting? Yes No
- Have you ever tried beer, wine, or other liquor? Yes No When was the last time? _____
- Do you drink alcohol regularly? Yes No If so, how often? _____
- Have you ever been drunk? Yes No