Name: ___________________________________

Date: ________________

NEW PATIENT HISTORY: Adolescent Version (ages 13-17 years)

Allergies:

NONE Foods: ____________________________________ Environmental Allergies: _________________

Medications: ____

Other: ____

Family History: (please put an "x" in the appropriate box)

Arthritis	Mother	Father	Sibling	Grandparent	Aunt/Uncle
Cancer	Mother	Father	Sibling	Grandparent	Aunt/Uncle
Diabetes	Mother	Father	Sibling	Grandparent	Aunt/Uncle
Heart problems	Mother	Father	Sibling	Grandparent	Aunt/Uncle
High Blood Pressure	Mother	Father	Sibling	Grandparent	Aunt/Uncle
High Cholesterol	Mother	Father	Sibling	Grandparent	Aunt/Uncle
Stroke	Mother	Father	Sibling	Grandparent	Aunt/Uncle
Thyroid Problems	Mother	Father	Sibling	Grandparent	Aunt/Uncle
Obesity	Mother	Father	Sibling	Grandparent	Aunt/Uncle
Liver problems	Mother	Father	Sibling	Grandparent	Aunt/Uncle
Kidney Problems	Mother	Father	Sibling	Grandparent	Aunt/Uncle
Depression/Anxiety	Mother	Father	Sibling	Grandparent	Aunt/Uncle
Blood Disorders	Mother	Father	Sibling	Grandparent	Aunt/Uncle

SOCIAL HISTORY

Marital Status: Single Married Divorced Separated Widowed Cohabitating

Occupation: Disabled

Who lives with you? Home Foster Care Group Home

Education: Current Grade in School ________ Finished HS College

Do you use tobacco? Never Quit Date: ___________ Smoke (_____packs per day) Chew

Do you drink alcohol? Never Quit Date: ___________ rarely daily weekly special occasions

Are you sexually active? yes no

Females: Date of Last Menstrual Flow: __________

SURGICAL HISTORY:

Type of Surgery	Year of Surgery	Name of Surgeon

MEDICAL HISTORY: Have you ever had any of the following? **No Past Medical Problems**

allergies	cancer	hypertension	pulmonary embolism or blood clot in legs
anemia	cardiac arrest	hypothyroidism	seizures
arthritis	celiac disease	heart disease	shortness of breath
atrial fibrillation	depression	insomnia	sinus conditions
asthma	diabetes	irritable bowel syndrome	stroke
bleeding problems	drug/alcohol abuse	kidney problems	Other:
congestive heart failure	erectile dysfunction	liver problems	
chest pain	prolonged infections	menopause	
chronic fatigue syndrome	fibromyalgia	migraines/headaches	
coronary artery disease	GERD or frequent heartburn	osteoporosis	
	high cholesterol	nerve pain	

Immunizations: Out of Date Meningitis MMR Booster Influenza Hepatitis

Current Medications You Take (please include herbals supplements and any over-the-counter medications):

Signature and Date: