

TRIANGLE COMMUNITY PHYSICIANS, P.A.
 ADOLESCENT PATIENT HEALTH HISTORY FORM

Name: _____ Today's Date: _____

Age: _____ Date of Birth: _____ Date of last Physical: _____

Reason for visit/health issues to discuss:

1. _____ 3. _____
 2. _____ 4. _____

MEDICAL HISTORY		SURGICAL HISTORY	
Year	Medical problems/Illness/Hospitalization <input type="checkbox"/> None	Year	Prior Surgeries/Operations <input type="checkbox"/> None

CURRENT MEDICATIONS including over-the-counter medicines, herbs, vitamins, birth control pills	ALLERGIES medications/foods
<input type="checkbox"/> None	<input type="checkbox"/> None
Local Pharmacy:	
Mail in pharmacy:	

CHILDHOOD ILLNESSES
Have you ever had any of the following?: <input type="checkbox"/> Chicken pox <input type="checkbox"/> Mumps <input type="checkbox"/> Measles <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Cold sores

VACCINATIONS <i>Please bring most recent vaccine record</i>
Tetanus vaccine: Date: <input type="checkbox"/> Under 10 years ago <input type="checkbox"/> Over 10 years ago
Hepatitis B vaccine <input type="checkbox"/> Not received <input type="checkbox"/> Completed series (3 shots)
HPV vaccine (Cervical cancer) Date: <input type="checkbox"/> Not received

OTHER PHYSICIANS/CLINICS list all other current physicians caring for you (gynecologists surgeons, specialists, etc.)

PLEASE COMPLETE BACK SIDE OF FORM ➔

WOMEN'S HEALTH (if applicable)			
Pregnancies		Birth control: <input type="checkbox"/> none <input type="checkbox"/> pills <input type="checkbox"/> patch <input type="checkbox"/> IUD <input type="checkbox"/> tubal ligation <input type="checkbox"/> vasectomy <input type="checkbox"/> withdrawal <input type="checkbox"/> Condoms <input type="checkbox"/> trying to get pregnant	Pregnancy complications: <input type="checkbox"/> None <input type="checkbox"/> Diabetes <input type="checkbox"/> Blood pressure <input type="checkbox"/> Other _____
Total number pregnancies		Menstrual periods: Last period: _____ Age at 1 st period: _____ Age at menopause _____	Pap smears: Date: _____ Abnormals? Have you ever had any STD's? <input type="checkbox"/> No <input type="checkbox"/> Yes Specify:
Full term infants			
Premature infants			
Abortions/Miscarriages			
Living children			

SOCIAL HISTORY	
Living arrangements— you live with: <input type="checkbox"/> Both biologic parents <input type="checkbox"/> One biologic parent <input type="checkbox"/> Shared custody <input type="checkbox"/> Adoptive parents <input type="checkbox"/> Other, specify:	Home Environment: Indoor Smokers? <input type="checkbox"/> Yes <input type="checkbox"/> No Indoor Pets? <input type="checkbox"/> Yes <input type="checkbox"/> No Firearms? <input type="checkbox"/> Yes <input type="checkbox"/> No Lead paint <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Education: School : Grade : Any behavior/learning concerns?	Exercise: Type and how often: <input type="checkbox"/> None
Type Sex partners: <input type="checkbox"/> Men <input type="checkbox"/> Women <input type="checkbox"/> Both Number of sex partners: Lifetime: Last 6 mo	Diet: <input type="checkbox"/> No specific <input type="checkbox"/> Diabetic <input type="checkbox"/> Vegetarian <input type="checkbox"/> Low fat/low cholesterol
Caffeine: Type, Amount and how often: <input type="checkbox"/> None	Illicit drugs: <input type="checkbox"/> never <input type="checkbox"/> current <input type="checkbox"/> quit <input type="checkbox"/> Marijuana <input type="checkbox"/> Cocaine <input type="checkbox"/> IV drugs
Tobacco: <input type="checkbox"/> never <input type="checkbox"/> current <input type="checkbox"/> quit Average amount: How long?:	Home Electronics: Hours of TV watching per day: Hours of Computer/video games per day
Alcohol: <input type="checkbox"/> Never <input type="checkbox"/> occasional <input type="checkbox"/> regular <input type="checkbox"/> former alcoholic Average amount:	

FAMILY HISTORY			
	Age/Age of death	Illnesses	Cause of death
Father	<input type="checkbox"/> Living <input type="checkbox"/> Deceased		
Mother	<input type="checkbox"/> Living <input type="checkbox"/> Deceased		
Brothers	<input type="checkbox"/> Living <input type="checkbox"/> Deceased		
	<input type="checkbox"/> Living <input type="checkbox"/> Deceased		
	<input type="checkbox"/> Living <input type="checkbox"/> Deceased		
	<input type="checkbox"/> Living <input type="checkbox"/> Deceased		
Sisters	<input type="checkbox"/> Living <input type="checkbox"/> Deceased		
	<input type="checkbox"/> Living <input type="checkbox"/> Deceased		
	<input type="checkbox"/> Living <input type="checkbox"/> Deceased		
	<input type="checkbox"/> Living <input type="checkbox"/> Deceased		