New Patient Adolescent Medical Questionnaire 11-18 y/o

Name:____
Accompanied by today: ____
Who do you live with____

Would you like to talk to or be examined without your guardian? YES NO
What is the reason for your visit today?____

Current & Past Medical Problems

Current Medications (name & dose)
Please include vitamins, etc.

Allergies to medications, food or X-ray dye___________________________
Pharmacy Name and Phone Number ___________________________________
Past Surgical History, Operations, and Hospitalizations (include dates)

Do you have any warts that need removal?______________________________
Current Grade and School____
Current Grades(Average)____
Any recent changes in grades?____
Are there any concerns about school/ learning difficulties? _______________________

Sports/Activites/Clubs____

What do you and your ***friends and family*** do for fun? (with whom, where, and when?)

With Friends____

With Family____

Do you always wear a seatbelt in the car? _______________________________________

Are there firearms in your home? ____

Do you use safety equipment for sports and or other physical activities (for example, helmets for biking or skateboarding)? ____

Have you ever been picked on or bullied? Is that still a problem?

Do you feel the need to protect yourself? From whom? Do you still feel that way?

Girls Only:
________Age Period Started
________Last Menstrual Period
________Periods Regular
________Painful Periods
________Had Gynecologic Exam

Boys Only:
_______Abnormal testicular, penile or urinary symptoms

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Family History

	Living or Deceased	Age (Current or at time of death)	List All Medical Problems
Father			
Mother			
Siblings			

Vaccine	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
Dtap					
Hib					XXXXXX
IPV					XXXXXX
Prevnar					XXXXXX
Hepatitis B				XXXXXX	XXXXXX
MMR			XXXXXX	XXXXXX	XXXXXX
Varivax(Chicken Pox)			XXXXXX	XXXXXX	XXXXXX
Tdap/Td		XXXXXX	XXXXXX	XXXXXX	XXXXXX
Flu					
Meningitis					
Other					

Review Of Systems
(Check any you are currently experiencing or have significant history of)

Current	Past		Current	Past	
		Weight Loss/Gain			Constipation
		Fever			Blood in Stool
		Chills			Diarrhea
		Rash			Frequent Urination
		Headaches			Painful Urination
		Eye Problems			Hair Loss
		Allergies			Too Hot/Too Cold
		Ear Infection			Joint Pain
		Sinus Infections			Anxiety/Daily Worry
		Sore Throat			Depression
		Shortness of breath			Panic Attacks
		Wheezing or Asthma			Obsessive/Compulsive
		Cough			Mania
		Chest Pain or Pressure			Considered/Attempted Suicide
		Funny or Rapid Heartbeat			Smokes
		High Blood Pressure			Alcohol Use/Abuse
		Sleep Disorder			Drug Abuse
		Indigestion/Heartburn			Worries about weight
		Difficulty Swallowing			Exercises Excessively
		Nausea			Eating Disorder