

Longs Peak Family Practice, P.C.
1309 Sunset Street
Longmont, CO 80501
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Adolescent Medical History Form
12-17 years of Age

Today's Date _____

Patient Name _____ Date of Birth _____ Age _____

Male _____ Female _____

Please list **all** medications, vitamins, herbs and supplements you take _____

Allergies to Medications or Vaccinations _____

Preventative Care: When was your most recent (or copy of immunization record)

Hepatitis A shot _____ Hepatitis B Shot _____ Influenza shot _____

Measles, Mumps, Rubella (MMR) Shot _____ Tetanus (Td) _____ Pnuemovax _____

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

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

Hospitalizations/Operations and dates: _____

Date of last dental exam _____

Broken bones or severe injuries: _____

INJURY PREVENTION

(please circle)

Do you wear a seatbelt when riding in a car? Yes No

Do you wear a helmet when bicycling or skateboarding? Yes No

Do you wear sunscreen? Yes No

Does your home have smoke detectors? 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

DIET

Do you eat 5 servings of fruits and vegetables each day? Yes No

Do you drink 4 glasses of milk daily or get calcium from other sources? Yes No

Caffeine intake: None _____ Coffee _____ Cups/day _____ Soda _____ Cans/Day _____

SUBSTANCE USE

Have you ever tried smoking cigarettes?	Yes	No
Do you smoke regularly? If so, how many cigarettes/day? _____	Yes	No
Have you ever tried beer, wine or other liquor?	Yes	No
Do you drink alcohol regularly?	Yes	No
Do you use any "street drugs" such as marijuana, ecstasy and others? If so, which ones? _____	Yes	No
Have you ever driven or been in a car with someone under the influence of drugs or alcohol?	Yes	No

RELATIONSHIPS

Do have a friend you really like and feel you can talk to?	Yes	No
Are you dating someone regularly?	Yes	No
Do you have questions about sex, pregnancy or sexually transmitted diseases?	Yes	No
Do you have questions about birth control?	Yes	No

Review of Symptoms: Please indicate any current symptoms you have from the list below.

Constitutional/Endocrine

Fevers/Chills/Excessive Sweating
 Unexplained weight loss/gain
 Feeling tired a lot
 Insomnia

Gastrointestinal

Abdominal Pain
 Nausea/vomiting/diarrhea
 Constipation

Ears/Nose/Throat

snoring
 problems with teeth/gums
 frequent runny nose
 problems with teeth/gums

Genitourinary

Bedwetting
 Discharge from penis or vagina
 Pain with urination
 Problems with periods (females)

Neurological

Headaches

Allergy

hay fever/itchy eyes
 frequent sneezing

Eyes

blurred vision

Respiratory

cough/wheezy

Musculoskeletal

muscle/joint pain or swelling

Cardiovascular

Tire easily with exertion
 Shortness of breath
 palpitations

Skin

acne
 unusual moles

Blood/Lymph

unexplained lumps
 easy bruising/bleeding

Psychiatric/Emotional (please circle any that apply)

Speech problems, anxiety, stress, sleep problems, nightmares, depression, feeling sad, nail biting, bad temper, moody, learning difficulty, eating disorders.

FAMILY HISTORY

What illnesses run in your family?

Mother _____

Father _____

Brothers/Sisters _____

Please circle any conditions in your blood relatives:

Arthritis/Rheumatism

Asthma

Cancer

Diabetes

Heart Attack

Ulcers

High blood pressure

Stroke

Anemia

Epilepsy/Convulsions

Blood Clots

Migraine Headaches

Depression