SKYLANDS PEDIATRICS
ADOLESCENT HEALTH HISTORY FORM

Please have patient/teen complete before your physical exam

Name of Child _____ Birth date _____

Circle Yes or No to the following questions. **Explain** all 'Yes' responses in the space provided (to the right).

1. Injury or illness since last checkup? Yes / No _____
2. Chronic illnesses, hospitalizations or surgeries? Yes / No _____
3. Any medications, supplements, herbs of any type? Yes / No _____
4. Allergies to medications, insects or food? Yes / No _____
5. Dizziness, passed out, chest pain with exercise? Yes / No _____
6. History of high blood pressure or heart murmur? Yes / No _____
7. History of sudden death in a close relative <50 years old? Yes / No _____
8. Ever restricted from sports by a physician? Yes / No _____
9. Any skin problems? Yes / No _____
10. History of concussion, "knocked out", unconsciousness, memory loss, seizure, or severe/frequent headache? Yes / No _____
11. Problems while exercising in the heat? Yes / No _____
12. Asthma, allergies, wheezing, difficult breathing? Yes / No _____
13. Glasses, contacts, vision or eye problems? Yes / No _____
14. Strain, sprain, fracture, joint pain or swelling? Yes / No _____
15. For girls: How long ago was your last period? Yes / No _____
    Concerns regarding periods? Yes / No _____
16. Under the care of any other health care provider? Yes / No _____

FAMILY HISTORY: Please mark Yes or No – if Yes, list relationship of individual

Medical Condition	**Yes**	**No**	**If Yes, list relationship of individual**
Alcoholism			
Bleeding Problems			
Cancer, Breast/Ovarian			
Cancer, Colon			
Cancer, Melanoma			
Cancer, Prostate			
Heat Attack/Heart Disease			
Depression			
Diabetes			
High Cholesterol			
High Blood Pressure			
Stroke			
Substance Abuse			
Thyroid Disorders			
Other			

CONCERNS: Please review this list and check if you have a concern.

- ☐ Physical Development
- ☐ Weight
- ☐ Diet/Nutrition
- ☐ Relationships with parents and family
- ☐ Self image or self worth
- ☐ Depression
- ☐ Violent / gang activity /guns / weapons
- ☐ Smoking or chewing tobacco
- ☐ Alcohol use
- ☐ Sexual orientation (heterosexual, gay or bisexual)
- ☐ Sexually transmitted diseases (STDs)
- ☐ Emotional Development
- ☐ Sleep Patterns
- ☐ Amount of Physical Activity
- ☐ Choice of friends
- ☐ Excessive moodiness or rebellion
- ☐ Lying, stealing or vandalism
- ☐ School grades / absences
- ☐ Drug use
- ☐ Sexual behavior
- ☐ Pregnancy risk
- ☐ Any other concerns?_____