

**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.

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