

ADOLESCENT/ADULT HEALTH HISTORY

Date

07/08/15

Name

Molly N. Minns

1. What is the reason for your visit today? Shots & Physical
2. Is there anything about you and your health that we need to know? 0

- *3. List medicine, drugs, or food you are allergic to: none
- *4. List any medicines or drugs you take: none

5. Have YOU or anyone in your family had any of the following: (circle)

heart disease
high blood pressure
stroke

diabetes/sugar
blood problem or disease
cancer

tuberculosis
birth defects
mental retardation

nerve or mental problems
asthma
died before age 50
other "family" disease

none

6. Have you ever been in the hospital? yes Why? sprained ankle
7. Have you ever had surgery? yes Why? ganglion cyst removal. left hand
8. Have you ever had a serious accident? no
9. Have you had serious or recent problems with:

ears or throat ☒ NO YES
allergies ☒ NO YES
lung infections ☒ NO YES

cough ☒ NO YES
thyroid ☒ NO YES
skin problems ☒ NO YES

kidneys ☒ NO YES
weight loss ☒ NO YES
ulcers ☒ NO YES

gallbladder ☒ NO YES
liver ☒ NO YES
depression ☒ NO YES
headaches ☒ NO YES

10. Have you ever had a seizure, convulsion, or "falling out" spell? ☒ NO YES
11. Have you ever had a blood clot in your lungs, legs or anywhere? ☒ NO YES
- *12. Have you ever smoked cigarettes or used smokeless tobacco? ☒ NO YES
- If yes, are you an: Ex-smoker? Smoking now? Do you smoke (less) (more) than a pack a day?
- How much smokeless tobacco do you use a day? _____
- *13. How often do you drink beer, wine, wine coolers, or liquor?
- ☒ Never ☐ Rarely ☐ 1-2 times a week ☐ 3-4 times a week ☐ 5 or more times a week
- If you drink beer, wine, wine coolers, or liquor, do you have:
- (less) (more) than 5 drinks a day?

- *14. Have you ever used marijuana, cocaine, crack or other drugs? ☒ NO YES
- *15. Have you ever used I.V. drugs? ☒ NO YES
16. Have you ever had a blood transfusion? ☒ NO YES
17. Do you have any tattoos? ☒ NO YES
18. Have you ever been treated for a venereal disease? ☒ NO YES
19. Have you had more than one sex partner in the past 5 years? ☒ NO YES
20. Have you ever had sex with a member of your own sex? ☒ NO YES
21. Have you had or been around anyone with hepatitis? ☒ NO YES
22. Would your sex partner(s) answer Yes to any of the questions 14-22? ☒ NO YES

FOR FEMALES ONLY

- A. How old were you when you started your periods? 14 Date of your last period? June 29-July 3, 2015
- How often do you have your periods? monthly Are they regular? yes
- How many days do they last? 4-5
- Do you have: (circle) bad cramps bleeding or spotting between periods unusual discharge NO
- B. Do you have any problems with your breasts (lumps, discharge, or other)? ☒ NO YES
- Do you check them regularly? ☒ YES NO
- *C. How many times have you ever been pregnant? 0 How many children are living? _____
- Have you ever had any children born dead; any stillbirths, miscarriages, or abortions? ☒ NO YES
- Were any of your children premature? ☒ NO YES
- How old were you when your first child was born? _____
- D. Have you ever used: (circle NO/YES) birth control pills? ☒ NO YES; foam? ☒ NO YES; condoms? ☒ NO YES; IUD? ☒ NO YES;
- diaphragm? ☒ NO YES
- E. Did you have problems with any of these methods? ☒ NO YES
- F. Have you ever had an abnormal PAP smear? ☒ NO YES