

ADOLESCENT/ADULT HEALTH HISTORY

Date _____

Name _____

1. What is the reason for your visit today? Tightness when breathing - R. side
2. Is there anything about you and your health that we need to know? Allergies
3. List medicine, drugs, or food you are allergic to: None
4. List any medicines or drugs you take: OTC - Claritin

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

<u>heart disease</u> - Father	diabetes/sugar	tuberculosis	nerve or mental problems
high blood pressure	blood problem or disease	birth defects	<u>asthma</u> - Brother
stroke	<u>cancer</u> - Mother	mental retardation	died before age 50
	<u>CML - leukemia</u>		other "family" disease

6. Have you ever been in the hospital? YES Why? C-sections (2) and Severe Strep Throat
7. Have you ever had surgery? NO Why? Outpatient - tubal ligation
8. Have you ever had a serious accident? NO
9. Have you had serious or recent problems with:

ears or throat	<u>NO</u> YES	cough	<u>NO</u> YES	kidneys	<u>NO</u> YES	gallbladder	<u>NO</u> YES
allergies	<u>NO</u> YES	thyroid	<u>NO</u> YES	weight loss	<u>NO</u> YES	liver	<u>NO</u> YES
lung infections	<u>NO</u> YES	skin problems	<u>NO</u> YES	ulcers	<u>NO</u> YES	depression	<u>NO</u> YES
						headaches	<u>NO</u> 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? 4

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? _____ Date of your last period? _____

How often do you have your periods? _____ Are they regular? _____

How many days do they last? _____

Do you have: (circle) bad cramps bleeding or spotting between periods unusual discharge
- 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? _____ 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