

ADOLESCENT/ADULT HEALTH HISTORY

Date _____ Name _____

1. What is the reason for your visit today? Sinus & congestion
2. Is there anything about you and your health that we need to know? hyperlipidemia
3. List medicine, drugs, or food you are allergic to: Reglan
4. List any medicines or drugs you take: _____

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

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

6. Have you ever been in the hospital? yes Why? testicular descent
7. Have you ever had surgery? yes Why? same
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?
- *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