

ADOLESCENT/ADULT HEALTH HISTORY

Date 10-14-14Name Asham, Ryttes

1. What is the reason for your visit today? Stomach Problems, Cycle Issues, Depression
2. Is there anything about you and your health that we need to know? _____

*3. List medicine, drugs, or food you are allergic to: _____

*4. List any medicines or drugs you take: _____

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

6. Have you ever been in the hospital? _____ Why? _____

7. Have you ever had surgery? _____ Why? _____

8. Have you ever had a serious accident? To the head on car end

9. Have you had serious or recent problems with:

ears or throat

NO YES

cough

NO YES

kidneys

NO YES

gallbladder

NO YES

allergies

NO YES

thyroid

NO YES

weight loss

NO YES

liver

NO YES

lung infections

NO YES

skin problems

NO YES

ulcers

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? 13Date of your last period? May 2014How often do you have your periods? RarelyAre they regular? NoHow many days do they last? 4Do 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? 0How many children are living? 0

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? No ChildD. 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