_____
Name

Adolescent Medical History: Parent/Guardian Form

PLEASE COMPLETE BOTH **(2)** PAGES

DO YOU HAVE ANY CONCERNS ABOUT YOUR ADOLESCENT'S HEALTH OR BODY? _____

_____

_____

PLEASE LIST ALL MEDICATIONS, VITAMINS, HERBS AND SUPPLEMENTS HE/SHE IS TAKING:

Name	Dose (for example, mg/pill)	How many times per day	When started

ALLERGIES/REACTIONS TO MEDICINES or VACCINATIONS: _____

_____

PREVENTIVE CARE: When were his/her most recent:

Hepatitis A shot _____	Hepatitis B shot_____	Influenza (flu shot) _____	Measles shot _____
Pneumovax shot ____	Rubella shot _____	Tetanus (Td) shot _____	
Varicella (chicken pox) shot or illness _____	PPD (Tuberculosis skin test) ____	Dental Exam _____	

PERSONAL MEDICAL HISTORY: Please list any major medical problems and their dates.

_____

_____

_____

Hospitalizations/Operations (with dates): _____

_____

Broken bones or severe injuries (with dates): _____

_____

INJURY PREVENTION:

Does your home have smoke detectors?	❑ Yes	❑ No
Is there a gun in your home?	❑ Yes	❑ No
If so, is it kept unloaded and locked out of reach?	❑ Yes	❑ No
Do anyone in the home smoke cigarettes or use other tobacco products?	❑ Yes	❑ No

In the past year, have there been any changes in your family? (Check all that apply)

❑ Marriage	❑ Loss of job	❑ Birth
❑ Separation	❑ Move to new neighborhood	❑ Serious illness
❑ Divorce	❑ Change to new school	❑ Death
		❑ Other changes/stresses

over ☛

FORM n0230 (January 2003)

FAMILY HISTORY:
Please indicate the current status of your immediate family members:
Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

Alcoholism _____ **High Cholesterol** _____
Cancer, specify type _____ **High Blood Pressure** _____
Heart Attack _____ **Stroke** _____
Depression/Suicide _____ **Other** _____
Diabetes _____ **Other** _____

CONCERNS: Please review this list and check if you have a concern about your adolescent:

- ❑ Physical development
- ❑ Weight
- ❑ Diet/nutrition
- ❑ Relationships with parents and family
- ❑ Self image or self worth
- ❑ Depression
- ❑ Violence / gang activity / guns / weapons
- ❑ Smoking or chewing tobacco
- ❑ Alcohol use
- ❑ Sexual orientation (heterosexual, gay or bisexual)
- ❑ Sexually transmitted diseases (STDs)
- ❑ Emotional development
- ❑ Sleep patterns
- ❑ Amount of physical activity
- ❑ Choice of friends
- ❑ Excessive moodiness or rebellion
- ❑ Lying, stealing or vandalism
- ❑ School grades / absences
- ❑ Drug use
- ❑ Sexual behavior
- ❑ Pregnancy risk

What seems to be the greatest challenge for your adolescent? _____

_____

What about your adolescent makes you proud? _____

_____

Is there anything you would like to discuss today privately? _____

_____