Adolescent Questionnaire

To be completed by parent/guardian

Date _______________ Patient's Name ____
Date of Birth ________________ Age __________
Reason for today's visit: ____
Other concerns or health-related goals I want to address (may need to occur at future visit): _____________
____
Drug Allergies ____
Other Allergies ____
What are you health goals for the next year? ____
Where were you getting your care before? ____
Have you been to the Emergency Room in the past 6 months? □Yes □No How many times? ___________

CURRENT MEDICATIONS: including over-the-counter and herbal

Medication	Dose	Frequency
1)		
2)		
3)		
4)		

Are there any of your current medications that you do not understand or have questions about? □Yes □ No
Are there any barriers to you taking your medications as prescribed? □Yes □No
Pharmacy Name/Location: ____
The following item(s) apply to today's visit (mark all that apply):
□ I need med refills
□ I need a note for school/work
□ I need lab work done
□ I need a referral to a specialist
□ I have a form I need filled out

MEDICAL HISTORY

Please check if you currently have or have had any of the following:
□ Anxiety
□ Allergies
□ Asthma
□ Diabetes
□ Depression
□ Irregular Periods

Other medical problems not listed: ____

FAMILY MEDICAL HISTORY

(Indicate health issues of the following family member, such as cancer, heart disease, high blood pressure, mental illness, allergies, arthritis, diabetes, or any other health concerns.)
Mother: ___________________________________
Father: ___________________________________
Sibling: ___________________________________
Sibling: ___________________________________
Maternal Grandmother: ___________________
Paternal Grandmother: ____________________
Maternal Grandfather: ____________________
Paternal Grandfather: _____________________

SURGICAL PROCEDURES:

1)____
2)____
3)____
4)____

VACCINATIONS

Please check if you have received the following vaccines and indicate approximate dates.
□ Tetanus Date: _______________
□ Pneumonia Date: _______________
□ Shingles Date: _______________
□ HPV (series of 3) Date: _________
□ Hepatitis A (series of 2) Date: __________
□ Hepatitis B (series of 3) Date: __________
□ Meningitis Date: ______________________
□ Chicken pox (varicella) Date: __________
□Had the disease Date: __________
□ Influenza Date: _______________

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Mt. Oread Family Practice
Affiliated with Lawrence Memorial Hospital

Adolescent Questionnaire

To be completed by patient

Date _______________ Name ____ Date of Birth ________________

Over the past 2 weeks, how often have you been bothered by any of the following problems?	**Not At All**	**Several Days**	**More Than Half the Days**	**Nearly Every Day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

SOCIAL HISTORY

Have you ever had sex? □ Yes □ No Last sexual encounter: _______________ Boys/Girls/Both
Are you interested in getting tested for sexually transmitted infection? □ Yes □ No
Do you ever drink alcohol? □ Yes □ No Last time: ________________________
Have you ever smoked? □ Yes □ No Cigarettes/Marijuana/Meth/Cigar Last time: ___________________
Do you use seatbelts? □ Yes □ No Do you drive? □ Yes □ No Do you text? □ Yes □ No
Do you use any social media sites? □ Yes □ No If yes, which ones? ___________________________________
What stresses you? ____
Are there things you don't or can't eat? ____
What do you do for exercise? ____

Female Only:

Date last period began _________ If you do not have periods, when did they stop? _____________
Age of first period __________ Current method of birth control _________________________________
Have you ever had a Pap? □Yes □ No

Please circle if you are having any of the following problems:
Constitutional: [Fever] [Chills] [Sweats][Weakness] [Fatigue] [Decreased Activity]
Eyes: [Recent visual problems] [Discharge] [blurring] [Double Vision] [Visual disturbances]
ENT: [Decreased hearing] [Ear pain] [Nasal congestion] [Sore throat]
Respiratory: [Shortness of breath] [Cough] [Sputum production] [Coughing up blood] [Wheezing] [Apnea]
Cardiovascular: [Chest pain] [Palpitations][Slow heart rate] [Fast heart rate] [Swelling] [Fainting]
Gastrointestinal: [Nausea] [Vomiting] [Diarrhea] [Constipation] [Heartburn] [Abdominal pain] [Vomiting blood]
Genitourinary: [Pain with urination] [Blood in urine] [Change in urine stream] [Urethral discharge] [Lesions]
Gynecologic: [Painful periods] [Hot flashes] [Intermenstrual bleeding]
Hema/Lymph: [Bruising tendency] [Bleeding tendency] [Swollen lymph glands]
Endocrine: [Excessive thirst] [Frequent urination] [Cold intolerance] [Heat intolerance] [Excessive hunger]
Immunologic: [Immunocompromised] [Recurrent fevers] [Recurrent infections] [General discomfort]
Musculoskeletal: [Back pain] [Neck pain] [Joint pain] [Muscle pain] [Lower leg pain] [Decreased range of motion] [Trauma]
Skin: [Rash] [Itching] [Abrasions] [Sores] [Burns] [Dryness] [Broken blood vessels] [Skin lesion] [Raised scar]
Neurologic: [Abnormal balance] [Confusion] [Numbness] [Tingling] [Headache]
Psych: [Anxiety] [Depression] [Mania] [Suicidal] [Delusional] [Hallucinations]

Other items not mentioned above: ____

We are happy to request medical records from other medical providers for documentation purposes.

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