Today's Date: _____

MULTNOMAH COUNTY student HEALTH CENTER

Name: _____
DOB: ____/____/____
MRN: _____ (or place label here)

Adolescent Medical History
(Ages 12-21)

This can be completed by the adolescent or the parent/guardian. If parent or guardian is completing, answer the questions about your child's health history. You can skip questions if you don't know the answer. This information will help us give you better care.

Do you need help filling out medical forms? ❑ Yes ❑ No

How do you learn best?
❑ Reading information ❑ Hearing information ❑ Pictures ❑ Learn by doing (hands on)

How do you want to get information?
❑ In writing ❑ Tell me ❑ Show me

ADOLESCENT MEDICAL HISTORY

1. Have you had an allergic reaction (bad effect) from any of the following?
❑ I have no allergies I know about ❑ Medicines/Drugs (please describe) _____
❑ Latex (rubber gloves) ❑ Eggs ❑ Peanuts ❑ Bee stings ❑ Shellfish
❑ Other (please describe) _____

2. Are you taking any medicines/drugs (include non-prescription, herbs, fluoride, vitamins, or supplements) daily? ..... YES ❑ NO ❑
If yes – please list:

3. Please check any conditions or symptoms you have on the list below.

- ❑ Allergies (seasonal, hay fever, etc)
- ❑ Asthma
- ❑ Autoimmune disorder (lupus/juvenile arthritis/celiac disease)
- ❑ Blood disorders (sickle cell/clotting problems)
- ❑ Cancer: Type _____
- ❑ Problems since birth (genetic disorders or syndromes)
- ❑ Diabetes: (circle one) pre-diabetes, type 1, or type 2
- ❑ Heart problems (including a murmur or high blood pressure)
- ❑ High cholesterol
- ❑ Chest pain, difficulty breathing, wheezing, or coughing with exercise
- ❑ Broken bones: where? _____
- ❑ Period problems
- ❑ Other _____
- ❑ Cavities or tooth pain/injuries
- ❑ Dizziness, fainting, or heat-related illness
- ❑ Many headaches/migraines
- ❑ Vision, hearing or speech problems
- ❑ Head injury, concussion or seizures
- ❑ Missing or damaged organs (eye, kidney, testicle)
- ❑ Urinary, kidney problems, testicle problems
- ❑ Eating disorders (like throwing up after eating, not eating enough, or eating too much)
- ❑ Learning disability or special education needs (IEP or 504 plan)
- ❑ Mental health condition (ADHD, anxiety, depression, etc.)
- ❑ Autism Spectrum Disorder
- ❑ Stomach problems: Type_____
- ❑ Is there any reason why the adolescent should not participate in sports or was ever refused participation for medical reasons?

4. Have you had any surgeries, major injuries, or been in the hospital overnight? ..... YES ❑ NO ❑
If yes – what surgeries/injuries or why were you in the hospital?

ORAL HEALTH

5. Do you go to the dentist regularly (at least once a year)? ..... YES ❑ NO ❑
When was the last visit?

FLIP OVER FOR ADDITIONAL QUESTIONS

FAMILY MEDICAL HISTORY

Medical problems can run in families. Please check the boxes below to tell us about any health problems your family members have had.

Mother (biological): Living? ❑ Yes ❑ No ❑ I don't know ❑ Has no medical problems
❑ Diabetes (sugar) ❑ Kidney problems ❑ Heart problems
❑ Stroke/Blood clots ❑ Alcohol/Drug abuse ❑ High blood pressure
❑ Mental health conditions (depression, anxiety, ADHD, Bipolar Disorder, etc.)
❑ Cancer: what type? _____ ❑ Other _____

Father (biological): Living? ❑ Yes ❑ No ❑ I don't know ❑ Has no medical problems
❑ Diabetes (sugar) ❑ Kidney problems ❑ Heart problems
❑ Stroke/Blood clots ❑ Alcohol/Drug abuse ❑ High blood pressure
❑ Mental health conditions (depression, anxiety, ADHD, Bipolar Disorder, etc.)
❑ Cancer: what type? _____ ❑ Other _____

Sister/Brothers: How many? _____
Living? ❑ Yes ❑ No ❑ I don't know ❑ Has no medical problems
❑ Diabetes (sugar) ❑ Kidney problems ❑ Heart problems
❑ Stroke/Blood clots ❑ Alcohol/Drug abuse ❑ High blood pressure
❑ Mental health conditions (depression, anxiety, ADHD, etc.)
❑ Cancer: what type? _____ ❑ Other _____

6. Does anyone in your home smoke cigarettes? ..... YES ❑ NO ❑

HEALTH CONCERNS – PARENT/GUARDIAN TO COMPLETE

7. Do you have any concerns about your child's health or safety that you would like to discuss? ..... YES ❑ NO ❑

8. Do you have concerns that your child may be using tobacco, alcohol, or drugs? ..... YES ❑ NO ❑

9. Do you have concerns about your child's school work or attendance? ..... YES ❑ NO ❑

10. Does your child seem sad, worried, or depressed, or express feelings or have behaviors that seem out of the ordinary for someone his or her age? ..... YES ❑ NO ❑

11. Do you have concerns about your child's involvement in sexual activity? ..... YES ❑ NO ❑

12. Is your family having any difficulties that we should know about while caring for your child? ..... YES ❑ NO ❑

13. Within the last 12 months I worried whether food would run out before I got money to buy more. ❑ Often true ❑ Sometimes true ❑ Never true ❑ Don't know

14. Within the past 12 months the food we bought just didn't last and we didn't have money to get more. ❑ Often true ❑ Sometimes true ❑ Never true ❑ Don't know

15. What is your housing situation today?
❑ We have permanent housing.
❑ We do not have permanent housing. We live:
❑ with others ❑ on the street/camp/bridge ❑ in a shelter ❑ in transitional housing

Patient Signature: _____

Parent/Guardian Signature: _____

for office use: Provider
Reviewed by: _____ Date: _____