Total Family Care

Affiliated with Lawrence Memorial Hospital

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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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/Other Drugs 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]
Heme/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.