QUESTIONNAIRE: NEW ADOLESCENT PATIENT (12 – 17 Years)

Patient Name: _____ Date of Birth: _____

Preferred Name/Nickname: _____ Today's Date: _____

Birth History

Place of Birth: _____

Birth Weight: _____

Problems at Birth: Yes No

_____

_____

_____

Number of days in the hospital: # _____

Premature? ☐ Yes ☐ No If so, how much? _____

Medical History

Hospitalizations: Yes No

- Why? _____
  When? _____
  Where? _____
- Why? _____
  When? _____
  Where? _____

Surgeries: Yes No

- Type of surgery? _____
  When? _____
  Where? _____
- Type of surgery? _____
  When? _____
  Where? _____

Allergic to Medications: ☐ Yes ☐ No

Medication	Reaction
_____	_____
_____	_____
_____	_____

Environmental/Food Allergies: Yes No

Allergy	Reaction
_____	_____
_____	_____
_____	_____

Medical History:

Condition	Year diagnosed/Specialist Name
☐ Asthma	_____
☐ Wheezing	_____
☐ Pneumonia	_____
☐ Ear Infections	_____
☐ ENT Disorders	_____
☐ Hearing Problems	_____
☐ Visions Problems	_____
☐ Gastrointestinal Disorder	_____
☐ Bladder/Urine Infections	_____
☐ Fractures	_____
☐ Behavior Problems	_____
☐ Developmental Concerns	_____
☐ Other _____	

Medications Prescribed and over-the-counter. Include vitamins, herbs, and home remedies.

Medication	Dose	Times Per Day

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Patient Label

QUESTIONNAIRE: NEW ADOLESCENT PATIENT (12 – 17 Years) (cont'd)

Social History

Are you sexually active?

☐ Never ☐ Not currently ☐ Yes - ☐ Male Partners ☐ Female Partners

Tobacco Use: ☐ Cigarettes ☐ Never
☐ Pipe Quit Date _____
☐ Cigar Packs/day _____
☐ Snuff # of years _____
☐ Chew # cartridges/day: ____
☐ Vaping

Caffeine: ☐ Yes ☐ No ☐ Cups/day _____

Alcohol: ☐ Yes ☐ No ☐ Drinks/wk _____

Drug Use:

Have you ever used non-legalized drugs?
Yes No

Have you ever used needles to inject drugs?
Yes No

Other Concerns:

Regular exercise: Yes No

What kind? _____

How long (minutes) _____ # _____/week

Your safety:

Is violence at home a concern? Yes No

Have you ever been abused? Yes No

Mother's Pregnancy History

Prenatal Care No Yes Where/Name of Provider: _____

Any medical problems during your pregnancy? No Yes If so, please list: _____

_____

List medications taken during pregnancy, both for the pregnancy and routine as prescribed by your doctor. Include vitamins, herbs, and home remedies.

Medication	Dose	Times Per Day	Medication	Dose	Times Per Day

Tobacco Use During Pregnancy: Never
Cigarettes Packs/day _____ Other _____

Alcohol Intake During Pregnancy: Yes No Drinks/week _____
Is alcohol a concern for you/others? Yes ☐ No

Drug Use During Pregnancy: (Including cannabis/marijuana) Yes No What kind? _____

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QUESTIONNAIRE: NEW ADOLESCENT PATIENT (12 – 17 Years) (cont'd)

Family History of Child:

Check all that applies to each family member.	AGE	Mental Health Disorder	ADHA/ Learning Disorders	Alcohol/Drug abuse	Cancer	Leukemia	Diabetes	High Blood Pressure	High Cholesterol	Respiratory disorder	Heart disease	Birth defects	Seizure disorder	Cause of Death
Mother														
Father														
Sisters														
Brothers														
Maternal Grandfather														
Maternal Grandmother														
Paternal Grandfather														
Paternal Grandmother														
Other:														

Does your child spend time with a parent that is not living in the household? ◯ Yes ◯ No

Please explain: _____

Please list all people living in your child's household: _____

_____

Does anyone that lives with your child smoke? ◯ Yes ◯ No

I have carefully reviewed this questionnaire and have completed it to the best of my knowledge.

Parent/Legal Representative Signature: _____ Date: _____ Time: _____

Relationship to Patient: _____

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