Patient Name: _____

Date of Birth: _____

Date: _____

Newport Children's Medical Group

ADOLESCENT INTAKE HISTORY

This information will be confidential between you and your doctor.

1. By what name do you like to be called?_____
2. Why are you coming to the doctor today? _____

Medical History

Chronic medications: _____

Previous infections/problems:

Anemia	☐ no	☐ yes	_____
Asthma	☐ no	☐ yes	_____
Behavior problem	☐ no	☐ yes	_____
Bladder or Kidney infection	☐ no	☐ yes	_____
Chronic Illness	☐ no	☐ yes	_____
Constipation	☐ no	☐ yes	_____
Convulsions or seizures	☐ no	☐ yes	_____
Drugs/tobacco/alcohol problem	☐ no	☐ yes	_____
Ear infection	☐ no	☐ yes	_____
Eczema	☐ no	☐ yes	_____
Hay fever	☐ no	☐ yes	_____
Learning problems	☐ no	☐ yes	_____
Pneumonia	☐ no	☐ yes	_____
Sleep problems	☐ no	☐ yes	_____
Transfusion	☐ no	☐ yes	_____
Vision problems	☐ no	☐ yes	_____
Weight problem	☐ no	☐ yes	_____
Other _____	☐ no	☐ yes	_____

Social History

Are you dating?	☐ no	☐ yes	_____
Do you go steady?	☐ no	☐ yes	_____
Do you feel depressed?	☐ no	☐ yes	_____
Do you have any worries about your sex feelings?	☐ no	☐ yes	_____
Do you get along with your brothers and sisters?	☐ no	☐ yes	_____
Are there any big problems at home?	☐ no	☐ yes	_____
Do you have any problems making friends?	☐ no	☐ yes	_____
Can you talk to your parents about important things or worries?	☐ no	☐ yes	_____
Do you smoke?	☐ no	☐ yes	_____
Marijuana?	☐ no	☐ yes	_____
Cigarettes?	☐ no	☐ yes	_____
Do you use other drugs?	☐ no	☐ yes	_____
Do you drink alcoholic beverages?	☐ no	☐ yes	_____

Family History

Alcohol or drug problem	☐ no	☐ yes	_____
Allergies	☐ no	☐ yes	_____
Asthma	☐ no	☐ yes	_____
Birth defects	☐ no	☐ yes	_____
Blood diseases	☐ no	☐ yes	_____
Blindness	☐ no	☐ yes	_____
Cancer	☐ no	☐ yes	_____
Convulsions	☐ no	☐ yes	_____
Elevated cholesterol/trigly	☐ no	☐ yes	_____
Deafness	☐ no	☐ yes	_____
Death in childhood (incl SIDS)	☐ no	☐ yes	_____
Diabetes	☐ no	☐ yes	_____
Headaches/migraines	☐ no	☐ yes	_____
Heart defects (incl congenital)	☐ no	☐ yes	_____
Heart attacks	☐ no	☐ yes	_____
At what age: _____	☐ no	☐ yes	_____
Hypertension	☐ no	☐ yes	_____
Immune deficiency (incl AIDS)	☐ no	☐ yes	_____
Learning problems	☐ no	☐ yes	_____
Liver disease	☐ no	☐ yes	_____
Lung disease	☐ no	☐ yes	_____
Mental retardation	☐ no	☐ yes	_____
Psychiatric disorders	☐ no	☐ yes	_____
Thyroid disease	☐ no	☐ yes	_____
Tb test – positive results	☐ no	☐ yes	_____

Conditions that run in the family: _____

_____

_____

Female Adolescents

Age at start of menstruation	_____		_____
Date of last pap smear			
Duration of period	_____		_____
Frequency of menstrual cycle: every	_____days		
Are periods regular?	☐ no	☐ yes	_____
Do you have menstrual cramping?	☐ no	☐ yes	_____
Do you do monthly breast exam?	☐ no	☐ yes	_____
Number of pregnancies (if any)	☐ no	☐ yes	_____
Number of miscarriages (if any)	☐ no	☐ yes	_____
Number of abortions (if any)	☐ no	☐ yes	_____

Male/Female

Sexually active?	☐ no	☐ yes	Age started ____
# of partners: _____			
Birth Control Method:	☐ IUD	☐ Pills	☐ Shot (Depo)
	☐ Foam	☐ Condom	☐ Diaphragm
	☐ Other		
Do you use condoms/safe sex?	☐ no	☐ yes	_____
Exposure to passive smoke	☐ no	☐ yes	_____
Smoker in household	☐ no	☐ yes	_____

Household Parent/Caretaker

Name	Age	Employer
_____	_____	_____
_____	_____	_____

☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Other _____

Others in Home

Name	Age	Relation to Patient
_____	_____	_____
_____	_____	_____

Others important in adolescent's life

Name	Age	Employer
_____	_____	_____
_____	_____	_____

This information has been reviewed with the patient:

Completed by: _____

Signature: _____ Date: _____