

## Adolescent/Young Adult Health History Form For Patients Aged 13+

**TO BE COMPLETED BY PATIENT:** This worksheet gives your doctor information to help you take better care of your health. Leave questions blank if you feel they don't apply to you. Your answers are confidential, which means we will not share information with others without your permission unless we are concerned about your safety.

Name \_\_\_\_\_

Phone number \_\_\_\_\_ Is it okay to leave a message?  Yes  No

What are your main reasons for today's visit? \_\_\_\_\_

### School and Activities

What school do you go to? \_\_\_\_\_ What grade/year? \_\_\_\_\_

Are you having a hard time in school? .....  No  Yes

Do you have a job? .....  No  Yes

What is it? \_\_\_\_\_ How many hours per week? \_\_\_\_\_

What sports, activities or hobbies do you do? \_\_\_\_\_

How many hours of screen time (smartphone, TV, computer games, etc) do you spend most days?  
 < 2  2-4  5-8  > 8

Do you get at least 30 minutes of exercise at least 3 times a week? .....  Yes  No

### Nutrition

Do you eat breakfast every day? .....  Yes  No

Do you eat fruits and vegetables every day? .....  Yes  No

Do you eat or drink dairy products (e.g. milk, yogurt, cheese) ? .....  Yes  No

Are you a vegetarian or do you restrict your diet in other ways? .....  No  Yes

Do you ever eat in secret or feel guilty about eating? .....  No  Yes

Have you ever tried to lose weight by vomiting, taking pills, or starving yourself? .....  No  Yes

### Family and Peers

Who do you live with? \_\_\_\_\_

Do you get along with the people you live with? .....  Yes  No

Are you having a hard time with kids at school or other peers or friends? .....  No  Yes

Do you have at least one trusted friend you can talk to about any problems you may have? .....  Yes  No

Do you have at least one caring adult you feel comfortable talking to? .....  Yes  No

### Stress and Mood

Over the past 2 weeks, have you lost interest or pleasure in doing things?  
 No  Several days  More than half the days  Nearly every day

Over the past 2 weeks, have you been feeling down, depressed or hopeless?  
 No  Several days  More than half the days  Nearly every day

**PLEASE TURN OVER**



Patient Name:

DOB:

MRN:

Clinic Location:

**Safety/Violence**

- Do you feel safe at home? .....  Yes  No
- Do you feel safe at school or your job? .....  Yes  No
- Do you always wear a helmet when riding a bicycle, motorcycle or skateboard? .....  Yes  No
- Do you always wear your seatbelt in the car? .....  Yes  No
- Have you ever ridden in a car driven by someone who was "high" or drunk? .....  No  Yes
- Are there any guns in your home? .....  No  Yes
- Do you feel afraid in any of your relationships? .....  No  Yes
- Have you ever been physically or sexually abused by anyone (hit, kicked, pushed, forced or tricked into having sex, or touched in a way that made you uncomfortable)? .....  No  Yes

**Tobacco, Alcohol and Other Drugs**

- Have you ever used tobacco (smoke, chew, e-cigarettes) or other vapor product? .....  No  Yes
- Does anyone you live with smoke or chew tobacco? .....  No  Yes
- Have you ever tried beer, wine or other alcohol? .....  No  Yes
- Have you ever used drugs like marijuana, cocaine, speed, etc? .....  No  Yes
- Does anyone in your family drink alcohol or use drugs so much that it worries you? .....  No  Yes

**Sexuality**

- Are you attracted to: .....  Males  Females  Both  Not sure
- Are you, or do you wonder if you are, gay, lesbian, bisexual or transgender? .....  No  Yes
- Are you currently dating or going out with someone? .....  No  Yes
- Have you ever had sex? .....  No  Yes
- If yes, are/were your partners: .....  Male  Female  Both
- If you have sex, how often do you use a condom: .....  Always  Sometimes  Never

**Health Issues**

Please check if you have questions or are worried about any of the following:

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Height             | <input type="checkbox"/> Neck or back      | <input type="checkbox"/> Constipation/diarrhea  | <input type="checkbox"/> Skin            |
| <input type="checkbox"/> Weight             | <input type="checkbox"/> Breasts           | <input type="checkbox"/> Arm or leg pain        | <input type="checkbox"/> Anger/temper    |
| <input type="checkbox"/> Diet/food/appetite | <input type="checkbox"/> Heart             | <input type="checkbox"/> Menstrual period       | <input type="checkbox"/> Feeling tired   |
| <input type="checkbox"/> Eyes/vision        | <input type="checkbox"/> Cough or wheeze   | <input type="checkbox"/> Wetting the bed        | <input type="checkbox"/> Violence/safety |
| <input type="checkbox"/> Hearing/earaches   | <input type="checkbox"/> Chest pain        | <input type="checkbox"/> Trouble urinating      | <input type="checkbox"/> Sleep           |
| <input type="checkbox"/> Runny/stuffy nose  | <input type="checkbox"/> Trouble breathing | <input type="checkbox"/> Genitals/private parts | <input type="checkbox"/> Stress/sadness  |
| <input type="checkbox"/> Mouth/teeth/breath | <input type="checkbox"/> Stomach ache      | <input type="checkbox"/> Wet dreams             | <input type="checkbox"/> Cancer          |
| <input type="checkbox"/> Headaches          | <input type="checkbox"/> Throwing up       | <input type="checkbox"/> Birth Control/STDs     | <input type="checkbox"/> Other _____     |

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Reviewed by (Provider Signature) \_\_\_\_\_ Date \_\_\_\_\_

