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:

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

Patient Signature _____ Date_____

Reviewed by (Provider Signature) _____ Date_____

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