Cornerstone Family Practice 13-17 year old Health History Form

Name:_____
Date Today:_____ Birthdate:_____
Age Today:_____

Family Status: Primary Caretakers_____
Siblings names and ages:_____
Any behavioral problems?_____
_____

Nutrition: Is your teenager eating a balanced diet ?_____
Are they eating "junk foods"?_____

Sleep: How many hours of sleep does your teenager get per night?_____

Social: Does your teen perform well or poorly in school?_____
Do they interact well or poorly with peers?_____
Do they participate in extra-curricular activities? If so, what types?_____
_____

Have you had discussions with your son/daughter about
Cigarette Smoking?_____ Alcohol?_____
Sex?_____ Birth Control ?_____
Condoms?_____ Drug Experimentation?_____
Any concerns?_____

Medical History: Please list any medical problems.

1.	3.
2.	4.

Surgical History: Please list any surgeries and dates.

1.	3.
2.	4.

Immunizations: Is your teen up-to-date?_____

Medications: Please list any medications your teen is taking and dosages.

1.	3.
2.	4.

Allergies: Please list any medication/environmental/food allergies and type of reaction.

1.	3.
2.	4.

Any other concerns you'd like to discuss today?_____
_____

FAMILY HISTORY: Please list family members with the following diseases

Note relationship to you and whether mother's (M) or father's (F) side of your family.

Alcohol/Drug Abuse	Skin Cancer
Asthma/Allergies	Thyroid Cancer
Birth Defect/Genetic Disease	Depression/Psychiatric Problems
Breast Cancer	Diabetes
Cervical Cancer	Heart Disease/Attack
Colon Cancer	High Blood Pressure
Lung Cancer	High Cholesterol
Ovarian Cancer	Migraines
Prostate Cancer	Stroke