

CROSS TRAILS MEDICAL CENTER
PATIENT HISTORY
ADOLESCENT LIFECYCLE
(Ages 12-19 years)

Date Completed: ____/____/____

PLEASE FILL IN ALL INFORMATION AS COMPLETE AS POSSIBLE.

NAME: _____ DATE OF BIRTH: ____/____/____

PAST MEDICAL HISTORY:

Current Medications: _____

Allergies: _____

Previous Surgery: _____

Previous Illness: _____

Previous Hospitalizations: _____

SOCIAL HISTORY:

Occupation: _____ Number of siblings: _____ (brothers) _____ (sisters)

Risk Assessment

Do you smoke / chew? (circle your answer) Yes / No
Estimate how much you smoke or chew _____ for how many years? _____

Do you drink alcohol? (circle your answer) Yes / No
If yes, estimate how much you drink _____ daily _____ weekends _____ weekly _____ monthly

Do you use street drugs? (circle your answer) Yes / No
If yes, how often _____
What kinds do you use _____

How are you doing in school? (circle your answer) good fair poor

Do you ever feel depressed or feel like you want to hurt yourself or someone else? Yes / No

Do you have any questions or concerns about birth control or condom use? Yes / No

FAMILY HISTORY:

Please list any illnesses and what family member has them (e.g. Mother: diabetes)

CROSS TRAILS MEDICAL CENTER
PATIENT HISTORY
ADOLESCENT LIFECYCLE
(Ages 12-19 years)

REVIEW OF SYSTEMS: (CIRCLE "YES" or "NO" AS APPROPRIATE)

HEENT

Frequent Headaches Yes / No
Hearing Problems Yes / No
Vision Problems Yes / No
Allergy Symptoms Yes / No
Sinus Infections Yes / No
Frequent Ear Infections Yes / No

CARDIOVASCULAR

Heart Problems Yes / No
Irregular Heartbeat Yes / No
Heart Murmur Yes / No
Blood Pressure Problems Yes / No

MUSCULOSKELETAL

Joint Pain Yes / No
Sports Injury Yes / No
Do you tape/brace any joint
during sports? Yes / No

ENDOCRINE

Diabetes Yes / No
Excessive Thirst Yes / No
Excessive Urination Yes / No
Thyroid Problems Yes / No

GASTROINTESTINAL

Hepatitis Yes / No
Abdominal Pain Yes / No
Vomiting Yes / No
Are you pregnant? Yes / No
Poor Appetite or a Change
in your appetite? Yes / No

PREVENTION

Exercise Yes / No
Use seat belts Yes / No
Do you use a helmet when riding
a bicycle or skating? Yes / No

RESPIRATORY

Asthma Yes / No
- How often do you use your inhaler?

Bronchitis Yes / No
Pneumonia Yes / No

NEUROLOGICAL

Seizures Yes / No
Dizziness Yes / No
Fainting Yes / No
Concussion Yes / No

PSYCHOLOGICAL

Anxiety Yes / No
Depression Yes / No
Suicide Attempt Yes / No
Psychiatric Counseling Yes / No

SKIN

Itching Yes / No
Eczema Yes / No
Moles Yes / No
Excessive Sun Exposure Yes / No

GENITOURINARY

Urinary Tract Infection Yes / No
Sexually Transmitted Disease Yes / No
HIV / AIDS Yes / No
Venereal Warts / Lesions Yes / No

FEMALE

Vaginal Discharge / Lesions Yes / No
Pelvic Infection Yes / No
Menstrual Pain Yes / No
Painful Intercourse Yes / No
Date of last menstrual period _____
Date of last PAP smear _____
Type of contraception _____
Number of living children _____
Number of times pregnant _____

To assess your risk of cervical cancer:
Age of first intercourse _____
Number of sex partners _____

Please list any other healthcare providers you
have seen:
