TRIANGLE COMMUNITY PHYSICIANS, P.A.
ADOLESCENT PATIENT HEALTH HISTORY FORM

Name:_____ Today's Date:_____

Age: _____ Date of Birth:_____ Date of last Physical: _____

Reason for visit/health issues to discuss:

1._____ 3._____

2. _____ 4. _____

MEDICAL HISTORY		SURGICAL HISTORY	
Year	Medical problems/Illness/Hospitalization ❑ None	Year	Prior Surgeries/Operations ❑ None

CURRENT MEDICATIONS including over-the-counter medicines, herbs, vitamins, birth control pills	ALLERGIES medications/foods
❑ None	❑ None
Local Pharmacy:	
Mail in pharmacy:	

CHILDHOOD ILLNESSES
Have you ever had any of the following?: ❑ Chicken pox ❑ Mumps ❑ Measles ❑ Rheumatic fever ❑ Cold sores

VACCINATIONS *Please bring most recent vaccine record*		
Tetanus vaccine: Date:	❑ Under 10 years ago	❑ Over 10 years ago
Hepatitis B vaccine	❑ Not received	❑ Completed series (3 shots)
HPV vaccine (Cervical cancer) Date:	❑ Not received	

OTHER PHYSICIANS/CLINICS list all other current physicians caring for you (gynecologists surgeons, specialists, etc.)	

PLEASE COMPLETE BACK SIDE OF FORM ➔

WOMEN'S HEALTH *(if applicable)*			
Pregnancies		**Birth control:** ❑none ❑pills ❑patch ❑IUD ❑tubal ligation ❑vasectomy ❑withdrawal ❑ Condoms ❑trying to get pregnant	**Pregnancy complications:** ❑ None ❑ Diabetes ❑ Blood pressure ❑ Other _____
Total number pregnancies			
Full term infants		**Menstrual periods:** Last period:_____ Age at 1st period: _____ Age at menopause_____	**Pap smears**: Date: _____ Abnormals? Have you ever had any STD's? ❑ No ❑ Yes Specify:
Premature infants			
Abortions/Miscarriages			
Living children			

SOCIAL HISTORY	
Living arrangements— you live with: ❑ Both biologic parents ❑ One biologic parent ❑ Shared custody ❑ Adoptive parents ❑ Other, specify:	**Home Environment:** Indoor Smokers? ❑ Yes ❑ No Indoor Pets? ❑ Yes ❑ No Firearms? ❑ Yes ❑ No Lead paint ❑ Yes ❑ No ❑ Unknown
Education: School : Grade : Any behavior/learning concerns?	**Exercise:** Type and how often: ❑ None
Type Sex partners: ❑ Men ❑Women ❑Both Number of sex partners: Lifetime: Last 6 mo	**Diet:** ❑ No specific ❑ Diabetic ❑ Vegetarian ❑Low fat/low cholesterol
Caffeine: Type, Amount and how often: ❑ None	**Illicit drugs:** ❑never ❑current ❑quit ❑ Marijuana ❑ Cocaine ❑ IV drugs
Tobacco: ❑never ❑current ❑quit Average amount: How long?:	**Home Electronics:** Hours of TV watching per day: Hours of Computer/video games per day
Alcohol: ❑Never ❑occasional ❑regular ❑ former alcoholic Average amount:	

FAMILY HISTORY			
	Age/Age of death	Illnesses	Cause of death
Father	❑Living ❑Deceased		
Mother	❑Living ❑Deceased		
Brothers	❑Living ❑Deceased		
	❑Living ❑Deceased		
	❑Living ❑Deceased		
	❑Living ❑Deceased		
Sisters	❑Living ❑Deceased		
	❑Living ❑Deceased		
	❑Living ❑Deceased		
	❑Living ❑Deceased		