



New Patient Adolescent Medical Questionnaire 11-18 y/o

Name: _____
Accompanied by today: _____
Who do you live with _____

Would you like to talk to or be examined without your guardian? YES NO

What is the reason for your visit today? _____

Current & Past Medical Problems

Current Medications (name & dose)
Please include vitamins, etc.

Allergies to medications, food or X-ray dye _____

Pharmacy Name and Phone Number _____

Past Surgical History, Operations, and Hospitalizations (include dates)

Do you have any warts that need removal? _____

Current Grade and School _____

Current Grades(Average) _____

Any recent changes in grades? _____

Are there any concerns about school/ learning difficulties? _____

Sports/Activites/Clubs _____

What do you and your **friends and family** do for fun? (with whom, where, and when?)

With Friends _____

With Family _____

Do you always wear a seatbelt in the car? _____

Are there firearms in your home? _____

Do you use safety equipment for sports and or other physical activities (for example, helmets for biking or skateboarding)? _____

Have you ever been picked on or bullied? Is that still a problem?

Do you feel the need to protect yourself? From whom? Do you still feel that way?

Girls Only:

____ Age Period Started
____ Last Menstrual Period
____ Periods Regular
____ Painful Periods
____ Had Gynecologic Exam

Boys Only:

____ Abnormal testicular, penile
or urinary symptoms



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Family History

	Living or Deceased	Age (Current or at time of death)	List All Medical Problems
Father			
Mother			
Siblings			

Vaccine	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
Dtap					
Hib					XXXXXX
IPV					XXXXXX
Prevnar					XXXXXX
Hepatitis B				XXXXXX	XXXXXX
MMR			XXXXXX	XXXXXX	XXXXXX
Varivax(Chicken Pox)			XXXXXX	XXXXXX	XXXXXX
Tdap/Td		XXXXXX	XXXXXX	XXXXXX	XXXXXX
Flu					
Meningitis					
Other					

Review Of Systems

(Check any you are currently experiencing or have significant history of)

Current	Past		Current	Past	
		Weight Loss/Gain			Constipation
		Fever			Blood in Stool
		Chills			Diarrhea
		Rash			Frequent Urination
		Headaches			Painful Urination
		Eye Problems			Hair Loss
		Allergies			Too Hot/Too Cold
		Ear Infection			Joint Pain
		Sinus Infections			Anxiety/Daily Worry
		Sore Throat			Depression
		Shortness of breath			Panic Attacks
		Wheezing or Asthma			Obsessive/Compulsive
		Cough			Mania
		Chest Pain or Pressure			Considered/Attempted Suicide
		Funny or Rapid Heartbeat			Smokes
		High Blood Pressure			Alcohol Use/Abuse
		Sleep Disorder			Drug Abuse
		Indigestion/Heartburn			Worries about weight
		Difficulty Swallowing			Exercises Excessively
		Nausea			Eating Disorder