Delaware Valley Pediatric Associates

ADOLESCENT PATIENT HISTORY

Please complete this form prior to being seen by the provider. Answer each question as best you can. This information will help us get to know you better. If you have any questions, please discuss them with your provider.

Name: _____ Today's Date: _____ Age: ____ School Grade: ____

Reason for today's visit: _____

					COMMENTS:
1. Do you get along well with your parents?	YES	____	NO	____	
2. Do you get along well with your brothers and sisters?	YES	____	NO	____	
3. Do you have any really close friends?	YES	____	NO	____	
4. Do your parents get along well with each other?	YES	____	NO	____	
5. Have your parents ever considered separation or divorce?	NO	____	YES	____	
6. Is your family under any serious stress?	NO	____	YES	____	
7. Do you like to have your friends visit your home?	YES	____	NO	____	
8. Are you doing all right in school?	YES	____	NO	____	
9. Do you miss more than two days of school each month?	NO	____	NO	____	
10. Have you ever considered dropping out of school?	NO	____	YES	____	
11. Have you ever repeated a grade in school?	NO	____	YES	____	
12. Have you ever been sexually or physically abused?	NO	____	YES	____	
13. Do you smoke cigarettes?	NO	____	YES	____	
14. Have you ever been drunk?	NO	____	YES	____	
15. Do any of your friends use drugs?	NO	____	YES	____	
16. Do you use, or have you ever used in the past, any of the following: marijuana, crack, cocaine, heroine, or other street drugs?	NO	____	YES	____	
17. Have you ever driven in a car with someone who was drunk?	NO	____	YES	____	
18. Do you wear a helmet when on a bicycle?	YES	____	NO	____	
19. Is there a gun in your home?	NO	____	YES	____	
20. Have you ever been in trouble with the law?	NO	____	YES	____	
21. Do you have anyone to talk to about your problems?	YES	____	NO	____	
22. Is life generally okay for you?	YES	____	NO	____	
23. Have you lost a lot of weight recently?	NO	____	YES	____	
24. Do you worry that you are too fat or too thin?	NO	____	YES	____	
25. Do you exercise regularly?	YES	____	NO	____	
26. Do you do any volunteer or community service?	YES	____	NO	____	
27. Do you have any special interests or hobbies?	YES	____	NO	____	
28. For females patients:					
a. Do you have menstrual periods every month?	YES	____	NO	____	
b. Have you ever had a breast lump?	NO	____	YES	____	
c. Do you have a boyfriend/girlfriend?	NO	____	YES	____	
d. Have you ever been pregnant?	NO	____	YES	____	
e. Are you concerned you might be pregnant?	NO	____	YES	____	
29. For male patients:		____		____	
a. Do you have a girlfriend/boyfriend?	NO	____	YES	____	
b. Are you concerned that you might get someone pregnant?	NO	____	YES	____	
c. Have you ever had sores or discharge from your penis?	NO	____	YES	____	
d. Do you examine your testicles for lumps?	YES	____	NO	____	
30. Have you ever seriously thought about hurting yourself?	NO	____	YES	____	

31. Have you ever had any of the following problems? (circle if appropriate)

Anemia	Heart murmur	Thyroid problems	Frequent nervousness
Asthma	Hepatitis	Blood transfusion	Frequent headaches
Chlamydia	High blood pressure	Pain with urinating	Trouble sleeping
Gonorrhea	High cholesterol	Tire easily	Other: _____

32. Please circle if you would like to discuss any of the following topics with your doctor:

Acne	Sexual development	AIDS
Weight problems	Friend problems	Sex
Menstruation	Parent problems	Drugs
Pregnancy	Depression/sadness	Other: _____