

Portland Family Practice- Adolescent age 12 to 17

Dear patient, thank you for completing this form. Please bring it with you to your appointment.

Patient name: _____ Date of birth: _____

Race: _____ Ethnicity: _____ Language: _____

(If you would like to decline from answering any of the above questions- please add 'decline' to the line.)

Reason for visit: _____

Do you have any concerns today? _____

Do you get good grades? _____

Do you like School? _____ What grade are you? _____

Repeat any grade? _____

Do you get along with your parents? _____ your siblings? _____

Are you social/ have friends? _____

Do you eat a balanced diet, from the four food groups? _____

Do you have or participate in any extracurricular activities? _____

Do you exercise? _____

How much time do you spend using the computer and/or watching TV daily? _____ Hours

Do you use your seat belt? _____ are there guns in your home? _____

Are you driving yet? _____

Females: age you started your period? _____ Any problems? _____

Current Medication(s), including vitamins, supplements/herbs –dose and quantity:

Medical History: Has the patient had any of these problems:

Diabetes Cancer Asthma Bowel or Urinary problems Bleeding Disorder

Thyroid Disorder Kidney Disorder Skin problems

Psychiatric Disorder/Depression/Anxiety Movement or speech problems ADD/ADHD

Other: _____

Allergies to Medications: _____ Other: _____

Surgical History and dates: _____

Hospitalizations and dates: _____

-OVER-

Please complete both sides

Family History: please fill in any bubble that applies to your family history:

- Father Date of birth: _____ Alive Deceased High cholesterol Heart Disease
 Hypertension Diabetes Cancer _____ (type) Stroke Thyroid disease
 Kidney disease bleeding disorder Substance abuse Depression
 Psychiatric disorder other _____
- Mother- Date of birth: _____ Alive Deceased High cholesterol Heart Disease
 Hypertension Diabetes Cancer _____ (type) Stroke Thyroid disease
 Kidney disease bleeding disorder Substance abuse Depression
 Psychiatric disorder other _____
- Sibling(s): High cholesterol Heart Disease Hypertension Diabetes
 Cancer _____ (type) Stroke Thyroid disease Kidney disease
 bleeding disorder Substance abuse Depression Psychiatric disorder
 other _____
- Children: High cholesterol Heart Disease Hypertension Diabetes
 Cancer _____ (type) Stroke Thyroid disease Kidney disease
 bleeding disorder Substance abuse Depression Psychiatric disorder
 other _____
- Extended Family: High cholesterol Heart Disease Hypertension Diabetes
 Cancer _____ (type) Stroke Thyroid disease Kidney disease
 bleeding disorder Substance abuse Depression Psychiatric disorder
 other _____

Social/Habit History:

- Are you a current smoker?** Yes No Has never smoked
 Cloves Cigars Chew Second hand smoke exposure
- **Former Smoker:** How long has it been since you last smoked? Less than 1 month 1-3 months
 3-6 months 6-12 months 1-5 years 5-10 years More than 10 years
 - **Current smoker:** How often do you smoke cigarettes or other? Every day some days, but not every day
How many cigarettes a day do you smoke? 5 or less 6-10 11-20 21-30 31 or more
How soon after you wake up do you smoke your first cigarette? within 5 minutes
 6-30 minutes 31 minutes -1 hour after 1 hour
Are you interested in quitting? Ready to quit Thinking of quitting Not ready to quit

Travel outside US? NO _____ Yes = where? _____

Do you use a smoke detector in your home? Yes _____ No _____

Do you have pets? _____

Sexual history: Have you had sex in the last 12 months? (Vaginal, rectal, or oral)

Yes no With: Men Women both men and women

Do you use a method of STD prevention /protection? (Condom or dental dam) Yes No

How often: All of the time 90% Most of the time Half of the time 80% some of the time
 70% 60% 20% 10% 0%

Would you like to discuss STD prevention with your provider? Abstinence condoms other _____

Have you ever had an STD (sexually transmitted disease) Yes NO?

If yes, please specify: Chlamydia Gonorrhea Syphilis Herpes other _____

Female only: date of last Menstrual period: ___/___/___

Has anyone hit, punched, or physically hurt in the last year or since last seen? Yes No

Do you feel safe? Yes No

Vaccination history: Date(s) of last/series:

Tetanus/Adacel: _____

TB/PPD: _____

Meningococcal (Menactra or Menamune): _____

Gardasil/HPV: 1) _____ 2) _____ 3) _____

Hepatitis B: 1) _____ 2) _____ 3) _____

Hepatitis A: 1) _____ 2) _____

Review of Systems – 12 years to 18 years

Dear Parent/Patient: Please complete the following to help us provide complete care.
Mark anything that has occurred in the past week or 'none of the above'.

Please give to your Medical Assistant when done, thank you.

Constitutional: weight loss eating problems weight gain
 sleep problems decreased energy none of the above

Cardiovascular: heart murmur heart palpitations dizziness
 chest pain none of the above

Ear/Nose/Throat: runny nose/congestion eye discharge ear pain/discharge
 swollen glands throat pain none of the above

Dermatology: rash hair problems nail problems
 Eczema Acne none of the above

Gastroenterology: vomiting diarrhea constipation
 blood in stool heart burn decreased appetite none of the above

Musculoskeletal: muscle weakness muscle pain joint pain none of the above

Respiratory: cough wheezing shortness of breath none of the above

Urology: blood in urine foul smelling urine frequent urination painful urination
 none of the above

Infectious Disease: fever(s) recent illness exposure to sick contacts
 none of the above

Neurology: headaches vision problems hearing problems none of the above

Hematology: easy bruising bleeding gums nose bleeds none of the above

Psychology: low mood/depression anxiety concentration/attention problems
 none of the above

Female Reproductive: heavy/painful periods irregular periods vaginal discharge
 breast pain none of the above

Male Reproductive: groin pain groin swelling none of the above

PORTLAND FAMILY PRACTICE

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Phone: 503-233-6940
Fax: 503-236-2676

Patient Contact Information:

Date: _____

Patient: _____ DOB: _____

SS#: _____

Patient's Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell phone: _____

E-Mail Address: _____

Employer: _____

Employer Address: _____

Employer Phone: _____

Emergency Contact Information:

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell phone: _____

Local Relative/Friend not living in the same household:

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____

By signing below, I agree I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

By: _____

(Patient)

Date: _____

(OR)

By: _____

(Patient representative)

Date: _____

Description of Representative's Authority: _____