

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: Have you (or your child) had any of these problems..... Diabetes - Cancer

Asthma – Bowel or Urinary problems - Psychiatric Disorder – Depression - Anxiety

Bleeding Disorder – Thyroid Disorder - Kidney Disorder – Skin problems

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) _____
