CROSS TRAILS MEDICAL CENTER
PATIENT HISTORY
ADOLESCENT LIFECYCLE
(Ages 12-19 years)

Date Completed: _____/_____/_____

PLEASE FILL IN ALL INFORMATION AS COMPLETE AS POSSIBLE.

NAME: _____ DATE OF BIRTH: _____/_____/_____

PAST MEDICAL HISTORY:

Current Medications: _____

Allergies: _____

Previous Surgery: _____

Previous Illness: _____

Previous Hospitalizations: _____

SOCIAL HISTORY:

Occupation: _____ Number of siblings: _____ (brothers) _____ (sisters)

Risk Assessment

Do you smoke / chew? (circle your answer) Yes / No
Estimate how much you smoke or chew _____ for how many years? _____

Do you drink alcohol? (circle your answer) Yes / No
If yes, estimate how much you drink _____ daily _____ weekends _____ weekly _____ monthly

Do you use street drugs? (circle your answer) Yes / No
If yes, how often_____
What kinds do you use _____

How are you doing in school? (circle your answer) good fair poor

Do you ever feel depressed or feel like you want to hurt yourself or someone else? Yes / No

Do you have any questions or concerns about birth control or condom use? Yes / No

FAMILY HISTORY:

Please list any illnesses and what family member has them (e.g. Mother: diabetes)

_____

_____

_____

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REVIEW OF SYSTEMS: (CIRCLE "YES" or "NO" AS APPROPRIATE)

HEENT

Frequent Headaches	**Yes / No**
Hearing Problems	**Yes / No**
Vision Problems	**Yes / No**
Allergy Symptoms	**Yes / No**
Sinus Infections	**Yes / No**
Frequent Ear Infections	**Yes / No**

CARDIOVASCULAR

Heart Problems	**Yes / No**
Irregular Heartbeat	**Yes / No**
Heart Murmur	**Yes / No**
Blood Pressure Problems	**Yes / No**

MUSCULOSKELETAL

Joint Pain	**Yes / No**
Sports Injury	**Yes / No**
Do you tape/brace any joint during sports?	**Yes / No**

ENDOCRINE

Diabetes	**Yes / No**
Excessive Thirst	**Yes / No**
Excessive Urination	**Yes / No**
Thyroid Problems	**Yes / No**

GASTROINTESTINAL

Hepatitis	**Yes / No**
Abdominal Pain	**Yes / No**
Vomiting	**Yes / No**
Are you pregnant?	**Yes / No**
Poor Appetite or a Change in your appetite?	**Yes / No**

PREVENTION

Exercise	***Yes / No***
Exercise	***Yes / No***
Use seat belts	***Yes / No***
Do you use a helmet when riding a bicycle or skating?	***Yes / No***

RESPIRATORY

Asthma	**Yes / No**
- How often do you use your inhaler?	
_____	
Bronchitis	**Yes / No**
Pneumonia	**Yes / No**

NEUROLOGICAL

Seizures	**Yes / No**
Dizziness	**Yes / No**
Fainting	**Yes / No**
Concussion	**Yes / No**

PSYCHOLOGICAL

Anxiety	**Yes / No**
Depression	**Yes / No**
Suicide Attempt	**Yes / No**
Psychiatric Counseling	**Yes / No**

SKIN

Itching	**Yes / No**
Eczema	**Yes / No**
Moles	**Yes / No**
Excessive Sun Exposure	**Yes / No**

GENITOURINARY

Urinary Tract Infection	**Yes / No**
Sexually Transmitted Disease	**Yes / No**
HIV / AIDS	**Yes / No**
Venereal Warts / Lesions	**Yes / No**

FEMALE

Vaginal Discharge / Lesions	**Yes / No**
Pelvic Infection	**Yes / No**
Menstrual Pain	**Yes / No**
Painful Intercourse	**Yes / No**

Date of last menstrual period _____
Date of last PAP smear _____
Type of contraception _____
Number of living children _____
Number of times pregnant _____
To assess your risk of cervical cancer:
Age of first intercourse _____
Number of sex partners _____

Please list any other healthcare providers you have seen

_____

_____

Patient Name: _____

Patient Signature (If 18 or older): _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

(rev. 1/7/02)