ResourceCare
COMMUNITY HEALTH CENTER

HEALTH HISTORY
AGES 12 TO 17 YEARS

If needed, please ask for assistance in completing this form.
Si necesita ayuda para llenar estas formas, por favor de decirnos nosotros le podemos ayuda.

Today's Date: _____

PLEASE PRINT CLEARLY

Patient Name: _____ Date of Birth: _____ Age: _____

Please answer questions in reference to the teenage patient

MEDICAL HISTORY

Do you have any health problems? _____ Yes _____ No

If Yes, please explain: _____

Has your child ever been hospitalized for an illness or had surgery? _____ Yes _____ No If yes, please explain

Date	Reason

Have you had any serious injuries? _____ Yes _____ No If yes, please explain

Date	Injury

Do you take any medications regularly? _____ Yes _____ No If yes, please list

Medication	Taken For	Physician Prescribed

Are you allergic to any medicine? _____ Yes _____ No If yes, please list

Medication	Reaction

Have you ever had any of the following problems? Please list how old you were when it started.

	No	Yes	Age		No	Yes	Age
Acne				Hearing problems			
Asthma				Depression			
Bladder infection				Emotional problems			
Tuberculosis				Learning problems			
Chicken Pox				Sickle cell anemia or trait			
Mononucleosis				Stomach ulcer			
Hepatitis				Heart disease			
STD's				Diabetes			
Headaches				Thyroid			
Seizures/Epilepsy				Cancer			
Vision				Scoliosis/back problems			

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SPECIFIC HEALTH CONCERNS

Please check below if you have any questions or concerns about any of the following:

	Height		Chest Pain		Learning or School problems
	Blood Pressure		Coughing/Wheezing		Muscle or joint pain
	Acne		Wetting the Bed		Cancer
	Breasts		Frequent or painful urination		Dying
	Heart		Headaches		Menstruation/Periods
	Appetite		Trouble Sleeping		Pregnancy
	Stomach pain		Tiredness		Sexual organs/genitals
	Nausea/Vomiting		Vision problems		Physical or Sexual abuse
	Diarrhea/Constipation		Hearing Problems		Other: _____

FAMILY INFORMATION

Does any blood relative in your family have or had any of the following conditions?
(ex: Mother, Father, Brother, Sister, Grandmother or Grandfather, Aunts, Uncles or Cousins)

	No	Yes	If yes, please indicate which relative			No	Yes	If yes, lease indicate which relative
Cancer					Drug Abuse			
Heart Attack (<55 yrs)					Mental Illness			
High Blood Pressure					Learning Problems			
Diabetes					Tuberculosis			
Alcoholic					Stroke			

Who do you live with? _____

Have you ever lived away from home? _____ Yes _____ No If yes, please explain: _____

Do you have any family problems? _____ Yes _____ No If yes, please explain: _____

During the past year, have there been any of the following changes in your family:

	Marriage		Serious Illness		Birth(s)
	Death(s)		Separation		Divorce
	Loss of Job		Other: _____		

Patient's father/guardian's job: _____ Patient's mother/guardian's job: _____

Form completed by: _____ Patient _____Parent/Guardian _____Other: _____

AUTHORIZATION AND RELEASE

I certify to that I have read and understand the above information to the best of my knowledge.
The above questions have been accurately answered.

_____ _____ _____
Patient/Guardian Signature Printed Name Date