



## ADOLESCENCE QUESTIONNAIRE

NAME \_\_\_\_\_  
 AGE \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_  
 PRIMARY PHYSICIAN \_\_\_\_\_ REFERRED BY \_\_\_\_\_  
 REASON FOR OFFICE VISIT \_\_\_\_\_

**CURRENT MEDICATIONS (INCLUDE HOW LONG ON MEDICATION AND REASON)**

- |    |    |
|----|----|
| 1. | 4. |
| 2. | 5. |
| 3. | 6. |

DO YOU TAKE ASPIRIN? \_\_\_\_\_ YES \_\_\_\_\_ NO IF YES, MOST RECENT DOSE \_\_\_\_\_

ALLERGIES (medications, foods, etc. Please describe reaction)

**MEDICAL HISTORY—PLEASE LIST ALL MEDICAL PROBLEMS THAT YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST**

- |    |    |
|----|----|
| 1. | 4. |
| 2. | 5. |
| 3. | 6. |

**PAST SURGICAL HISTORY**

	<u>OPERATION</u>	<u>REASON</u>	<u>DATE</u>	<u>HOSPITAL</u>
1.				
2.				
3.				

DO YOU SMOKE? YES NO

DID YOU SMOKE? YES NO HOW MUCH? \_\_\_\_\_ HOW LONG \_\_\_\_\_ QUIT \_\_\_\_\_

**HAVE YOU HAD?**

Bleeding Problems .....	YES	NO	Blood Transfusions .....	YES	NO
Steroid/prednisone .....	YES	NO	Anemia .....	YES	NO
Diabetes .....	YES	NO	Thyroid Problems.....	YES	NO
Strokes/Phlebitis .....	YES	NO	Stomach Ulcers .....	YES	NO
Fevers.....	YES	NO	Hiatal Hernia .....	YES	NO
Glaucoma.....	YES	NO	Diarrhea/Constipation .....	YES	NO
Hepatitis.....	YES	NO	TB (Tuberculosis) .....	YES	NO
High Blood Pressure.....	YES	NO	Asthma .....	YES	NO
Heart Problems .....	YES	NO	Emphysema/Bronchitis .....	YES	NO
Heart Attack.....	YES	NO	Pneumonia.....	YES	NO
Chest Pain .....	YES	NO	Epilepsy/Seizures .....	YES	NO
Heart Failure .....	YES	NO	Rheumatic Fever .....	YES	NO
Ankle Swelling .....	YES	NO	Cancer .....	YES	NO
Most Recent EKG _____			Other _____		