Northern **M**ichigan **M**edicine and **P**ediatrics

Adolescent Annual Medical History Form (Ages 12 - 17)

Name: _____ Date of birth: _____

Name of adult accompanying you/child: _____ Relation: _____

Name(s) of parent/guardian: _____

_____

MEDICATIONS	Dose	Directions

Do you have any allergies? ☐NO ☐YES If yes, list allergy type and reaction: _____

_____

Are parents allergic to any medications? ☐NO ☐YES If yes, list parent, medication and reaction: _____

MEDICAL HISTORY (Please check (X) all that apply to patient):

☐ADD/ADHD ☐Acne ☐Anemia ☐Asthma ☐Autism Spectrum ☐Bleeding Disorder

☐Chicken Pox ☐Concussion/Closed Head Injury ☐Constipation ☐Diabetes: Type_____

☐Eczema ☐Ear Infections ☐Fracture:_____ ☐Headaches/Migraines ☐Hearing Problems

☐Heart Murmur ☐Heart Disease Congenital ☐Menstrual Problems ☐Reflux/GERD Disease

☐Urinary Tract Infections ☐Down Syndrome

Cancer or other conditions:

_____

_____

FEMALE HISTORY

Age at 1st period: _____ 1st day of most recent period: _____

Regular ☐ or Irregular ☐ Has not yet had menses: ☐

SURGICAL HISTORY

Type of Surgery	Date	Surgeon (If known)

OVER

FAMILY HISTORY	Age if Living	Age at Death	Heart Disease	High BP	Diabetes	Mental Illness	Cancer/Other (include type)
Father							
Paternal Grandfather							
Paternal Grandmother							
Mother							
Maternal Grandfather							
Maternal Grandmother							
Brother(s)							
Sister(s)							

SOCIAL HISTORY

Who lives at home _____

Do any household members smoke ☐YES ☐NO Smoke outside only ☐YES ☐NO

Are the parents: married, divorced, separated, living together, never together _____

School name _____ Grade _____

Does patient work or volunteer? ☐YES ☐NO Type/location/frequency: _____

Exercise / Sports ☐YES ☐NO Type _____Hours per day _____

Use of a seatbelt ☐Never ☐Sometimes ☐Always

Carbon monoxide detector in home ☐YES ☐NO Smoke detector in home? ☐YES ☐NO

Pets or animals at home ☐YES ☐NO If yes, what type_____

Sleeps through the night ☐YES ☐NO Average hours of sleep per night_____

Good appetite ☐YES ☐NO Other: _____

Tobacco use (including vaping, chewing, cigars)? ☐NO ☐YES If yes, please explain: _____

MENTAL HEALTH (PATIENT TO COMPLETE)	Not at all	Several days	More than half the days	Almost everyday
Over the **Last 2 Weeks**, how often have you been bothered by any of the following?				
1. Loss of interest or pleasure in doing things				
2. Feeling down, sad, depressed				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself, failure, letting yourself or your family down				
7. Trouble concentrating including reading the newspaper or watching TV				
8. Moving or speaking so slowly, fidgety or restless				
9. Thoughts that you would be better off dead or of hurting yourself in some way				