TOUCHPOINT PEDIATRICS, P.A.

Adolescent Medicine - Patient History

Patient Name: _____ Date: _____ School: _____ Grade: _____

Please answer the following questions.

THE INFORMATION WILL BE CONFIDENTIAL BETWEEN YOU AND YOUR DOCTOR.

1. What is the reason for this visit to the doctor? _____
2. Do you have any special questions or problems? _____
3. Do you think something is wrong with your health? Yes No
What? _____
4. Are you having problems at work or school? Yes No
What? _____
5. Are you having problems at home? Yes No
With whom? _____
6. Are you concerned with your growth or body development? Yes No
Explain _____
7. Do you ever diet? Yes No
8. Do you think you are: Just right ( ) Too fat ( ) Too thin ( )
9. Do you have stomach problems like pain, constipation or diarrhea? Yes No
Explain _____
10. Do you have burning or do you urinate too frequently? Yes No
11. Do you have muscle or joint pain? Yes No
12. Do you have any questions or concerns about drinking or use of drugs? Yes No
Explain _____
13. Do you ever experience any of the following problems?
Headaches ( ) Trouble sleeping ( ) Chest pain ( ) Dizziness ( ) Fainting spells ( ) Allergies ( )
Vomiting more than once a month ( )
14. Are you taking any medicine or drugs at this time? Yes No
What? _____
15. Do you drink alcoholic beverages? Yes No
What? _____ How often? _____
16. Do you smoke? Yes No
What? _____ How often? _____
17. Are you ever depressed? Yes No
Explain _____
18. Are you sexually active? Yes No

If the answer is Yes, answer the following questions:

19. Do you have more than one partner? Yes No
20. If sexually active, what type of contraception are you using? _____
2 l. Do you have any questions about birth control? ·Yes No
What? _____
22. Do you have any questions about discharge from your vagina or penis, or do you have questions about sexually transmitted diseases? Yes No
23. Do you have any questions about your sexual feelings?
Explain _____

Questions for Girls:

24. How old were you when you had your first period? _____
25. Are there any problems with your periods? _____
26. What are the approximate dates of the first day of your last two periods? _____
27. Do you have any questions or concerns about pregnancy? Yes No

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This accompanies the article "Point of View: How to Keep Adolescents in Your Practice" in the March 2000 issue of *Pediatric Practice Management* and is courtesy of Vickie Jackson of Southern Orange County Adolescent Care. *Pediatric Practice Management* (ISSN I 096-2778) (USPS 016-226) is published monthly by The Coding Institute, a unit of Global Success Corporation.
POSTMASTER: Send address changes to *Pediatric Practice Management,* 850 Sixth Avenue North, Bldg. 2. Naples, FL 34102. Periodical Postage Paid at Naples, FL.