

Date: _____

Patient Label

Teen Wellness Center HEALTH HISTORY

ALLERGIES (reaction?): _____ Medications: _____ Food: _____

Surgeries or hospitalizations: _____

Please check if patient or close family members have had problems with any of the following:

| | PATIENT | FAMILY | | PATIENT | FAMILY |
|--|---------|--------|--|---------|--------|
| Heart disease, including high blood pressure: | _____ | _____ | Nervous system, including headaches/seizures: | _____ | _____ |
| Lungs, including asthma: | _____ | _____ | Bones or Muscles including sprain, fractures: | _____ | _____ |
| Stomach or Colon: | _____ | _____ | Kidneys, including UTI: | _____ | _____ |
| Mouth or Throat, including teeth, braces: | _____ | _____ | Skin including, rashes, acne, eczema: | _____ | _____ |
| Endocrine, including diabetes or thyroid: | _____ | _____ | GYN or reproductive, # of children in the family: | _____ | _____ |
| Vision: glasses or contacts | _____ | _____ | Hearing: | _____ | _____ |
| Mental Health: substance abuse | _____ | _____ | Mental Health: depression, anxiety | _____ | _____ |
| For Females, age of first menses: | _____ | _____ | Blood: anemia, low iron | _____ | _____ |

ADDITIONAL INFORMATION: _____
