Patient Label _____

Date:____/_____/____

Teen Wellness Center
HEALTH HISTORY

ALLERGIES : Insects_____ Medications:_____ Food:_____

Surgeries or Hospitalizations: _____**Grade in School**:_____

Learning Problems in School:_____ **School Attending**:_____

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

	PATIENT	FAMILY		PATIENT	FAMILY
Cardiovascular System High blood pressure, heart Murmurs stroke	_____	_____	**Nervous System** Head or spinal injuries Headaches/seizures:	_____	_____
Respiratory System Asthma, bronchitis, pneumonia	_____	_____	**Bones, Muscles, Joints** Sprains, fractures, pain	_____	_____
Gastrointestinal System Diarrhea, constipation, eating Disorder, abdominal pain	_____	_____	**Kidneys** Urinary tract infections	_____	_____
Mouth or Throat Teeth problems, braces	_____	_____	**Skin** Rashes, acne, eczema	_____	_____
Endocrine System Diabetes or thyroid	_____	_____	**Reproductive System** Cancer of breast, ovaries Testicles	_____	_____
Vision Glasses or contacts	_____	_____	**Hearing**	_____	_____
			Mental Health/Habits		
Blood Blood clots, anemia (low iron) Sickle cell trait or disease	_____	_____	Depression, anxiety Alcohol, tobacco	_____ _____	_____ _____

Females Age of first menses: _____ Pregnancies: _____

Males Testicular Torsion: _____ Hydrocele: _____

List all medications you take: _____

ADDITIONAL INFORMATION:_____