



Adolescent Medicine – Parent History

(Parent(s) should fill this out)

Patient name: _____

Father: _____ Age: _____ Occupation: _____

Mother: _____ Age: _____ Occupation: _____

Marital Status: () Single () Married () Divorced () Separated () Widowed

Other Children's Names and Ages:

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History – Have any family members had (please circle all those that apply):

- | | |
|---------------------|---|
| Diabetes | Convulsions |
| High Blood Pressure | Allergies, Hay Fever, or Asthma |
| Cancer | Alcoholism/Drug Abuse |
| Tuberculosis | Obesity |
| Migraine Headaches | Heart Disease or stroke at age less than 60 |

Please circle Yes or No

Patients History

1. Has he/she ever had any serious short term or chronic illness? Yes No

If so, what and when? _____

2. Has he/she ever had any operations or hospitalizations? Yes No

If so, what and when? _____

3. Is he/she allergic to any medications? Yes No

If so, what? _____

Do you have any special questions regarding your child's health? _____

Do you have any questions or concerns regarding your adolescent's behavior?

PLEASE NOTE: Well health care visits are important to check on growth, development, nutrition and to provide guidance for your child. There may be time when you have a significant health concern or behavioral concern or a problem that we identify during your child's health check that will need to be addressed at a separate office visit in order to provide ample time for this concern.

Do we have your permission to treat your child in your absence? () Yes () No

Work Phone Number: Mother: _____ Father: _____

Parent's Signature: _____ Date: _____