AGAPE PHYSICIANS

Teenager History

Patient Name: _____
DOB: _____
Age: _____

Patients Previous Doctor: _____
Present Health Concerns: _____
Allergies to Medications: _____

Pregnancy

Type of delivery? (circle one) C-Section / Vaginal
If C-Section why? _____
Length of pregnancy: _____ weeks

Family History

Parents of the patient in good health? ☐ Yes ☐ No
Siblings of the patient in good health? ☐ Yes ☐ No

Please list medical conditions for the following family members:

Relative	Medical Conditions
Mother	
Father	
Siblings	
Siblings	
Siblings	
Maternal Grandparents	
Paternal Grandparents	

Social History

Are the parents of the patient:
☐ Married ☐ Divorced ☐ Separated ☐ Deceased
This patient lives with:

Name	Age	Relationship	Highest Education

Current school/grade? _____
Concerns about school performance? _____

Social Questions	Yes	No
Any concerns about bullying at school?		
Are there smokers in the home or people who smoke?		
Do you have a pool, spa, or pond?		
Does your teenager always use a seat belt?		
Does your teenager wear a helmet when riding a bike, skateboard, etc.?		
Do you have a record of immunization?		
Is there violence in the home?		
Are there guns in the home?		
Does your teenager wear sunscreen?		
Screen time per day? (TV, Computer, Phone, tablet, etc.)	___hrs / day	

Patient's Pharmacy: _____

Birth History

Place of birth: _____
Adopted? ☐ Yes ☐ No Birth Weight: _____
Problems at birth? ☐ Yes ☐ No
If yes explain? _____
Stay in NICU? ☐ Yes ☐ No If so, why? _____
Was patient breastfed? ☐ Yes ☐ No If so, how long? _____

Past Medical History

Allergies? ☐ Yes ☐ No List Allergies _____

Has the patient had:	Yes	No
Frequent ear infections		
Eye problems		
Frequent colds, sore throats		
Asthma, pneumonia, recurring cough		
Heart murmur or heart problems		
Problems with urine infections		
Frequent diarrhea or constipation		
Convulsions / seizures		
Eczema or skin conditions		
Anemia or blood problems		
Sleep problems		
Has your patient seen any specialists?		
Does the patient take homeopathic or herbal medicines?		

List other medical problems: _____

If not applicable, leave blank	Yes	No
Does the patient have any injuries that still bother them?		
Has the patient ever fainted during exercise?		
Any cough or shortness of breath while exercising?		
Any head injuries in the last 2 years affecting sports or school?		
Anyone in the family suddenly die while exercising?		
Does the patient get one hour of exercise daily?		
Does the patient get 3 servings of milk or calcium containing foods daily?		
Does the patient drink more than 6 oz juice/soda daily?		
Any concerns about the patient feeling depressed, down or hopeless?		
Any concerns about the patient feeling anxious?		
Any concerns about attention/hyperactivity?		

Medications patient takes regularly: _____

Hospitalizations & Operations

_____ Date
_____ Date