PRIMARY CARE SPECIALISTS, INC.

MEDICAL QUESTIONNAIRE - ADOLESCENTS AGE 13 - 17

Patient's Name _____

Date of birth _____Age_____ Acc#_____

Date of Visit_____

PAST HISTORY:

1. Do you now have or did you ever have any of these conditions? Check the appropriate box.

[ ] measles	[ ] asthma	[ ] diabetes
[ ] mumps	[ ] pneumonia	[ ] heart trouble
[ ] chicken pox	[ ] tuberculosis	[ ] high blood pressure
[ ] diphtheria	[ ] HIV / AIDS	[ ] kidney trouble
[ ] polio	[ ] liver trouble / hepatitis	[ ] seizures
[ ] sickle cell	[ ] mental illness	[ ] anemia
[ ] cancer	[ ] other_____	

2. List any hospitalizations, surgeries or serious injuries. Include the approximate dates:

_____

_____

_____

FAMILY HISTORY:

1. Is your mother living?____ If not, what did she die from? _____
2. Is your father living? ____ If not, what did he die from? _____
3. How many brothers? Living _____ Deceased _____ Sisters? Living _____ Deceased _____
4. How many children? Boys, Living _____ Deceased _____ Girls, Living _____ Deceased _____
5. Does any one in your family (mother, father, siblings, aunts, uncles, grandparents, etc.) have any of these following conditions? Check the appropriate box.

[ ] tuberculosis	[ ] heart disease	[ ] diabetes	[ ] hypertension
[ ] stroke	[ ] kidney disease	[ ] sickle cell	[ ] cancer_____
[ ] arthritis	[ ] liver disease	[ ] anemia	[ ] seizures
[ ] stomach/bowel disease	[ ] AIDS/HIV	[ ] migraines	[ ] other_____

ALLERGIES:

Are you allergic to any medications? ____ If so, what are they? _____

IMMUNIZATIONS:

Provide immunization / shot record for nurses to copy if available.
Have you had the following immunizations? Check the appropriate box.

[ ] small pox	[ ] measles	[ ] rubella	[ ] pertussis	[ ] tetanus
[ ] typhoid	[ ] mumps	[ ] diphtheria	[ ] polio	[ ] hepatitis

[ ] unsure or unknown

MEDICATIONS:

List all medications and their doses (if known) ?_____

_____

_____
If you brought your medications with you, show them to the nurse at the time of the interview.

HABITS:
1. How much alcohol, wine or beer do you drink per day, week, month, etc._____
   _____
2. Do you smoke? _____If so, how much a day? _____Number of years?_____
3. Do you use recreational or illicit drugs?_____ If so, what kind?_____

SOCIAL HISTORY:
1. What grade are you in school? _____
2. Do you have a job? _____If so, what is it?_____
3. What type of home do you live in? Check the appropriate box.
   [ ] house [ ] apartment [ ] condo [ ] Other_____
4. Who lives in the home with you? _____

REVIEW OF SYSTEMS:
If you have any of the following problems, please check the appropriate box.

HEENT
[ ] Decreased hearing
[ ] Failing or blurred vision
[ ] Sinus trouble
[ ] Hay fever / allergies
[ ] Frequent sore throat
[ ] Frequent eye infection
[ ] Frequent ear infections

CARDIOPULMONARY
[ ] Palpitations / Irregular heart beat
[ ] Chronic cough / bronchitis
[ ] Asthma / wheezing
[ ] Shortness of breath
[ ] Chest pain
[ ] Heart murmur

GENERAL
[ ] Dizzy spells
[ ] Fainting spells
[ ] Weight loss

URINARY
[ ] Frequent urination
[ ] Frequent urine infections
[ ] Painful urination
[ ] Blood in urine
[ ] Penis discharge
[ ] Vaginal discharge
[ ] Sexual diseases
[ ] Bed wetting

NEUROLOGICAL
[ ] Headaches - frequent
[ ] Seizures / convulsions
[ ] Muscle weakness

MUSCULOSKELETAL
[ ] Foot pain
[ ] Leg pain with walking
[ ] Back pain

OTHER
[ ] _____

GASTROINTESTINAL
[ ] Loss of appetite
[ ] Difficulty swallowing
[ ] Indigestion / heartburn
[ ] Stomach pain
[ ] Constipation
[ ] Bloody or black stools

SKIN
[ ] Hives / Itching
[ ] Rashes
[ ] Psoriasis / eczema

PSYCHIATRIC
[ ] Sleeping difficulty
[ ] Nervousness
[ ] Depression

FEMALES ONLY - Menstrual History
1. When was your last menstrual period? _____ Age when menses began ? _____
2. Are your periods regular? ____ Are they heavy, moderate or light? _____
3. Do you have severe pain or cramps with your menses? _____ Any abnormal bleeding?_____
4. How long does your period last? _____ How many days from one period to the next?_____
5. Any pain or bleeding following sex? _____
6. Number of pregnancies? _____ Live births? _____ Miscarriages? _____ Induced abortions? _____
7. What type of birth control do you use? _____
   If you use the pill, what is the name of it? _____
8. When was your pap smear? _____