**ADOLESCENT HEALTH HISTORY (ages 15-18) Birmingham Pediatrics+Wellness Center**

Please answer these questions privately. Give this form to your health care provider, who will be willing to discuss it with you. This information will not be shared with your parents unless we have your permission.

 Age \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade in school \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who lives in your household? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you attending school? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What grades do you usually receive? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your future school or job plans? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take any medicines (including birth control pills, diet pills, laxatives, steroids, vitamins)? \_\_\_\_\_\_\_\_\_\_\_

Have you been feeling sad about anything? . . . . . . . . . . . . . . . . . . . . . . . no \_\_\_\_\_ yes \_\_\_\_\_

Have alcohol or drugs caused a problem for you or someone you know? . . . . . . . . no \_\_\_\_\_ yes \_\_\_\_\_

Have you used alcohol or drugs? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . no \_\_\_\_\_ yes \_\_\_\_\_

How many times a week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use tobacco products (smoking, chewing)? . . . . . . . . . . . . . . . . . . . no \_\_\_\_\_ yes \_\_\_\_\_

Have you ever ridden in a car driven by someone (including yourself) who was “high” or drunk? \_\_\_\_\_\_\_\_\_\_\_

Have you ever had a suicide attempt? . . . . . . . . . . . . . . . . . . . . . . . . . . no \_\_\_\_\_ yes \_\_\_\_\_

Have you considered suicide? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . no \_\_\_\_\_ yes \_\_\_\_\_

Have you or anyone in your family been abused/raped/assaulted? . . . . . . . . . . . no \_\_\_\_\_ yes \_\_\_\_\_

Are you or any of your friends in a gang? . . . . . . . . . . . . . . . . . . . . . . . . no \_\_\_\_\_ yes \_\_\_\_\_

Do you ever wonder about being gay? . . . . . . . . . . . . . . . . . . . . . . . . . . no \_\_\_\_\_ yes \_\_\_\_\_

Have you ever had sexual relationships (gone all the way) with anyone? . . . . . . . . no \_\_\_\_\_ yes \_\_\_\_\_

Do you want more information about birth control? . . . . . . . . . . . . . . . . . . . no \_\_\_\_\_ yes \_\_\_\_\_
Do you have any questions about AIDS or other STDs such as gonorrhea or chlamydia? Please specify:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you having problems at home, school, or with friends? . . . . . . . . . . . . . . . no \_\_\_\_\_ yes \_\_\_\_\_

Are you worried about your height and/or weight? . . . . . . . . . . . . . . . . . . . no \_\_\_\_\_ yes \_\_\_\_\_

Has anyone ever touched you in a way that felt uncomfortable to you? . . . . . . . . . no \_\_\_\_\_ yes \_\_\_\_\_

What do you consider to be methods of safe sex? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any guns in your home? . . . . . . . . . . . . . . . . . . . . . . . . . . . . no \_\_\_\_\_ yes \_\_\_\_\_

How many times per week are you getting 30 min. or more of exercise? . . . . . . . . \_\_\_\_\_\_\_\_\_
Is there anything else you would like to discuss during your visit? Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we share this information with your parents? . . . . . . . . . . . . . . . . . . . . no \_\_\_\_\_ yes \_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your name (First Last): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ date of birth: \_\_\_/\_\_\_/\_\_\_\_ your cell phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Best way to reach you if we need to (circle one): email cell phone other (list below):

Initials of Provider reviewing form : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Reviewed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Form Revised Jan 2016