CAMPGROUND PEDIATRICS + WELLNESS CENTER
ADOLESCENT HEALTH HISTORY (AGES 15-18)

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: ______________________

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

Your name (First Last): ___________________________________ Date of Birth: ___/___/___ Cell # ____________

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: _________________