

Adolescent's Name _____ Age _____ Birth Date _____ Date _____
 Your Name _____ Relationship to Adolescent _____

ADOLESCENT HEALTH HISTORY

1. Is your adolescent allergic to any medicine? No Yes
 If yes, what? _____
2. List any medications your adolescent is taking now, and the problem for which the medication was given:

3. Has your adolescent ever been hospitalized overnight? No Yes
 If yes, please describe _____
4. Has there been any change in your adolescent's health during the past year? No Yes
 If yes, please describe _____
5. Has your son/daughter ever had any of the following health problems? **(Check all that apply)**

<input type="checkbox"/> Allergies	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Sports injuries or fractures
<input type="checkbox"/> Anemia or blood disorders	<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Bladder or kidney infections	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Ulcer or digestive problems
<input type="checkbox"/> Cancer	<input type="checkbox"/> Rheumatic fever or heart disease	<input type="checkbox"/> Mental illness or depression
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizures	_____
<input type="checkbox"/> Endocrine/gland disease	<input type="checkbox"/> Severe Acne	_____
6. If your adolescent received an immunization that has not been recorded with this office, please indicate immunization and date it was given (month/year).

Tetanus _____	Measles (MMR) _____	Varicella (chicken pox) _____
Hepatitis B #1 _____	#2 _____ #3 _____	Other _____

FAMILY HISTORY

1. Have you or any of you adolescent's blood relatives (parents, grandparents, siblings, aunts or uncles), living or deceased, had any of the following problems? **(Check all that apply)**

<input type="checkbox"/> Alcoholism/Drugs	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Lung disease/Tuberculosis
<input type="checkbox"/> Allergies/Asthma	<input type="checkbox"/> Endocrine/gland disease	<input type="checkbox"/> Mental health/Depression
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart attack or stroke	<input type="checkbox"/> Mental retardation
<input type="checkbox"/> Birth defects	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Obesity
<input type="checkbox"/> Blood disorder/Sickle Cell Anemia	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Seizures/Epilepsy
<input type="checkbox"/> Cancer	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Smoking
2. With whom does the adolescent live most of the time? **(Check all that apply)**

<input type="checkbox"/> Both parents in the same household	<input type="checkbox"/> Stepfather	<input type="checkbox"/> Sister(s)/ages _____
<input type="checkbox"/> Mother	<input type="checkbox"/> Guardian	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Father	<input type="checkbox"/> Alone	_____
<input type="checkbox"/> Stepmother	<input type="checkbox"/> Brother(s)/ages _____	_____
3. In the past year, have there been any changes in your family? **(Check all that apply)**

<input type="checkbox"/> Marriage	<input type="checkbox"/> Loss of a job	<input type="checkbox"/> Deaths
<input type="checkbox"/> Separation	<input type="checkbox"/> Move to a new house	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Divorce	<input type="checkbox"/> Change in school	_____
<input type="checkbox"/> Serious Illness	<input type="checkbox"/> Births	_____

DRS. ROTH, LEHOCKY, KATZ
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 LOUISVILLE, KY 40218

TO BE COMPLETED BY PARENT/GUARDIAN

PARENTAL/GUARDIAN CONCERNS:

Please review the topics listed below and check if this is a concern you have about *your* son or daughter or if you would like to discuss this topic:

- | | | |
|--|--|---|
| <input type="checkbox"/> Physical complaints | <input type="checkbox"/> Self image/Self worth | <input type="checkbox"/> Alcohol use |
| <input type="checkbox"/> Physical development | <input type="checkbox"/> Excessive moodiness/Rebellion | <input type="checkbox"/> Dating/Parties |
| <input type="checkbox"/> Weight | <input type="checkbox"/> Depression | <input type="checkbox"/> Sexual Behaviors |
| <input type="checkbox"/> Change of appetite | <input type="checkbox"/> Lying/Stealing, or vandalism | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Sleep patterns | <input type="checkbox"/> Violence | <input type="checkbox"/> Birth control |
| <input type="checkbox"/> Diet/Nutrition | <input type="checkbox"/> School | <input type="checkbox"/> Sexual Identity |
| <input type="checkbox"/> Amount of Physical Activity | <input type="checkbox"/> Grades/truancy/dropout | (heterosexual, homosexual) |
| <input type="checkbox"/> Emotional Development | <input type="checkbox"/> Smoking cigarettes | <input type="checkbox"/> Work or Job |
| <input type="checkbox"/> Relationship with family | <input type="checkbox"/> Chewing tobacco | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Choice of friends | <input type="checkbox"/> Drug Use | |

QUESTIONS FOR PARENT/GUARDIANS

1. Over the past year, your child's grades have been mainly A's & B's B's & C's C's & D's D's & F's
2. How many days of school has your child missed since the beginning of this school year? _____
3. Do you or another adult regularly supervise or keep track of your adolescent's activities? Yes No
4. Does your adolescent have a significant amount of unsupervised time each day, after school or in the evening? Yes No
5. How many hours per week does your child work outside the home? _____ 0 hrs _____ 10hrs _____ 20 hrs _____ 30 hrs
6. Have you discussed with your adolescent his/her use of alcohol/tobacco, or other drugs? Yes No
7. Have you discussed with your adolescent his/her sexual orientation and sexual behavior? Yes No
8. Have you discussed with your adolescent safe driving as a passenger and as a driver? Yes No
9. Have you discussed with your adolescent bike safety and rules of the road? Yes No
10. Have you discussed with your adolescent injury prevention in regard to swimming, on the job safety, sports, and operating machinery? Yes No
11. Is there a gun in your household? No Yes
If yes, is it secured/locked with ammunition stored separately? Yes No
12. Do you believe your parenting style and discipline techniques are effective to your adolescent? Yes No
13. Do you involve your adolescent in decisions about his/her health? Yes No
14. What do you do find most rewarding about being the parent of your adolescent?

15. What is it about your adolescent that makes you proud of him/her?

16. What do you and your adolescent do together on a regular basis (for example, have meals together)?

17. Do you have any additional questions or concerns? No Yes

PARENT AND GUARDIAN CHALLENGES

Health life styles and preventing measures should be part of everyone's daily routine. Your decisions about alcohol and other drugs, smoking, food choices, safety, and physical activity can strongly influence your adolescent's behavior and decisions. Parent/guardians demonstrate by their action what they believe or value.

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