



Beech Grove Family Physicians
Adolescent (Ages 11-17) Historical Summary

Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Parent / Guardian \_\_\_\_\_

Patient Medical History

Birth information: Birth weight \_\_\_\_\_ Mother's pregnancy: [ ] full-term [ ] premature \_\_\_\_\_ weeks Birth information: [ ] normal vaginal delivery [ ] C-section [ ] complications, if so describe \_\_\_\_\_ Did mother have any major illnesses / problems during pregnancy? [ ] yes [ ] no If yes, \_\_\_\_\_

Check any past / current patient problems

- [ ] confused [ ] unresponsive [ ] eyes [ ] ears [ ] nose [ ] mouth [ ] sinus [ ] throat [ ] skin problems [ ] rash [ ] pain: location [ ] problems with anesthesia, describe
[ ] hives [ ] hearing [ ] speech [ ] vision [ ] loose or chipped teeth [ ] capped or false teeth [ ] stomach problems [ ] weight loss [ ] weight gain [ ] bowel problems
[ ] liver problems / hepatitis [ ] gallbladder [ ] bladder [ ] kidney [ ] dialysis [ ] problems with reproductive organs [ ] blood clots [ ] circulation problems [ ] bleeding [ ] stroke [ ] cancer, location:
[ ] high blood pressure [ ] heart problems [ ] thyroid [ ] diabetes [ ] immune system problems [ ] bones [ ] difficulty walking [ ] frequent falls [ ] seizures [ ] weakness
[ ] too little sleep [ ] too much sleep [ ] lung problems [ ] breathing problems [ ] TB [ ] positive TB skin test date of last TB skin test [ ] other: please list

Explain any checked items: \_\_\_\_\_

List any previous hospitalizations / surgeries / invasive procedures: \_\_\_\_\_

[ ] immunizations up-to-date List any allergies \_\_\_\_\_

List current medications: \_\_\_\_\_

Family / Social History

Father's age \_\_\_\_\_ Mother's age \_\_\_\_\_ Parent's marital status: \_\_\_\_\_ [ ] Natural parents [ ] Adoptive parents [ ] Foster parents
Brother and / or sisters? If yes, names and ages \_\_\_\_\_ If both parents work, care provided by: [ ] day care center [ ] a sitter in a home [ ] relative [ ] other \_\_\_\_\_ Are there persons, living with the patient, who smoke? [ ] yes [ ] no
Unusual dietary habits: \_\_\_\_\_ Special Interests: \_\_\_\_\_ Is the patient sexually active? [ ] yes [ ] no Does the patient use? Tobacco? If yes, how much/day \_\_\_\_\_ x \_\_\_\_\_ years Caffeine? If yes, how much /day \_\_\_\_\_
Alcohol? If yes, how much \_\_\_\_\_ /day \_\_\_\_\_ /week Recreational drugs? If yes, type \_\_\_\_\_

Have you had a family member with any of the following? If so, check the appropriate box.

Table with 5 columns: Father, Mother, Children, Brothers/Sisters, Grandparents. Rows include: alcoholism, asthma, emphysema, tuberculosis, heart disease, kidney disease, high blood pressure, stroke, epilepsy/seizures, cancer, bleeding disorders, diabetes, thyroid disease, high cholesterol, genetic disease, migraine, mental illness, other.

Factors That May Affect Learning

Who is to be taught: [ ] patient [ ] other; if other, relationship to patient \_\_\_\_\_ Able to read: [ ] yes [ ] no [ ] with difficulty
Comments \_\_\_\_\_ Potential barrier to learning: [ ] none [ ] blind [ ] poor vision [ ] deaf [ ] decreased hearing
[ ] unable to talk [ ] memory loss [ ] learning disability [ ] inability to understand [ ] language, if other than English \_\_\_\_\_ Learns best by: [ ] reading [ ] verbal instruction [ ] practicing [ ] talking [ ] watching [ ] other \_\_\_\_\_ Are there any cultural or religious beliefs that need to be considered in the care? [ ] yes [ ] no If yes, explain \_\_\_\_\_

Signature \_\_\_\_\_ Relationship to patient \_\_\_\_\_ Date \_\_\_\_\_

Staff review : date/initials \_\_\_\_\_ date/initials \_\_\_\_\_ date/initials \_\_\_\_\_ date/initials \_\_\_\_\_ date/initials \_\_\_\_\_
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