GRANDVIEW FAMILY MEDICINE ADOLESCENT HEALTH HISTORY FORM

Today's date:					
Name:				Birthdate:	//
Last	First	Middl	e		
Patient signature:			Age:		
1 2	MAIN REASONS FOR THIS VISIT?			PHYSICIAN'S	COMMENTS
1 2 3	R SIGNIFICANT ILLNESSES YOU HA	AVE			
PERFORMED 1 2 3	CRIES AND THE YEAR IT WAS		HAPPENED 1 2 3	OKEN BONES AND	
Name of Medicine / 12	ATIONS YOU ARE TAKING Dose / Frequency:				
□ Latex □ Tape		ume		Gluten □ Milk	

Are you adopted? □ Yes \square No List the cause of death for those who have died **prior to age 50** (Do not include accidental deaths) Mother's Father _____ Father's Father Mother __ Mother's Mother _____ Father's Mother _ List any blood relatives that have the following illnesses/diseases. □ Alcoholism Mental Illness Alzheimer's/Dementia ☐ High Blood Pressure ☐ Cancer (Breast) ☐ Heart Attack prior to age 55 ☐ Cancer (Colon) ☐ Heart Disease ☐ Cancer (Prostate) ☐ High Cholesterol ☐ Cancer (Lung) ☐ Osteoporosis □ Stroke Cancer Diabetes (type_ Substance Abuse **Emotional Illness** ☐ Thyroid Disease **SOCIAL HISTORY** 1. Grade in School: 2. Your sex: □ Female □ Male 3. Race: □ Caucasian □ Hispanic □ Indian □ African American □ Asian □ Polynesian/Island □ Other: ______ 4. Religious Preference: □ LDS □ Catholic □ Baptist □ Jewish □ Protestant □ N/A □ Other: _____ 5. What is your smoking status? □ Non-Smoker □ Past □ Current 6. How many alcoholic drinks do you consume in one day? □ Non-Drinker \Box 1 – 2 \Box 3 or more 7. Do you follow a special diet? ☐ Gluten Free ☐ Low Fat /Calorie ☐ Vegetarian □ Other:_____

□ Yes

 \square No

8. Do you need help for a problem related to physical, verbal, or mental abuse?

FAMILY HISTORY