Patient Label

Date:____/______/_____

Teen Wellness Center
HEALTH HISTORY

ALLERGIES : Insects_________________ Medications:____________________ Food:__________________

Surgeries or Hospitalizations: _______________________**Grade in School**:___________________________

Learning Problems in School:________________________ **School Attending**:_________________________

Please check if patient or close family members have had problems with any of the following:

	PATIENT	FAMILY		PATIENT	FAMILY
Cardiovascular System High blood pressure, heart Murmurs stroke	_______	_______	**Nervous System** Head or spinal injuries Headaches/seizures:	_______	_______
Respiratory System Asthma, bronchitis, pneumonia	_______	_______	**Bones, Muscles, Joints** Sprains, fractures, pain	_______	_______
Gastrointestinal System Diarrhea, constipation, eating Disorder, abdominal pain	_______	_______	**Kidneys** Urinary tract infections	_______	_______
Mouth or Throat Teeth problems, braces	_______	_______	**Skin** Rashes, acne, eczema	_______	_______
Endocrine System Diabetes or thyroid	_______	_______	**Reproductive System** Cancer of breast, ovaries Testicles	_______	_______
Vision Glasses or contacts	_______	_______	**Hearing**	_______	_______
Blood Blood clots, anemia (low iron) Sickle cell trait or disease	_______	_______	**Mental Health/Habits** Depression, anxiety Alcohol, tobacco	_______ _______	_______ _______

Females Age of first menses: ________
Pregnancies: ________

Males Testicular Torsion: _________
Hydrocele: _________

List all medications you take: ____

ADDITIONAL INFORMATION:____