Medical Questionnaire
Ages 12 and Above

Teenager Name _____ Date of Birth _____
Questionnaire filled out by _____
Relationship to child _____
Date of visit _____

a. Has your teenager been diagnosed with any of these illnesses or medical conditions? (Check all that apply)

- ☐ Anemia
- ☐ Asthma
- ☐ Attention Deficit Disorder w/Hyperactivity (ADHD)
- ☐ Diabetes
- ☐ Head injury
- ☐ Heart murmur
- ☐ Nasal allergies/sinusitis
- ☐ Psychiatric or mental illness
- ☐ Seizures
- ☐ Urine/bladder infection
- ☐ Other specify_____

☐ **My teenager does not have any of these illnesses.**

b. Has your teenager ever been admitted to a hospital? ☐ No ☐ Yes

If yes,

a. What was the admission for? _____
b. How old was your child? _____
c. Name of hospital and city _____

c. Has your teenager ever had any surgeries? ☐ No ☐ Yes

If yes,

a. What was the surgery for? _____
b. How old was your child? _____
c. Name of hospital and city _____

d. Does your teenager have any allergies to food or medications? ☐ No ☐ Yes

If yes, please list _____
_____

e. Are your teenager's immunizations up to date, including HPV vaccine? ☐ No ☐ Yes

If no, which are pending? _____

f. Please check all that apply to your teenager's health at this time

- ☐ Loss of energy
- ☐ Weight loss
- ☐ Weight gain
- ☐ Gums bleed easily
- ☐ Bleeds for a long time after a cut
- ☐ Difficulty hearing
- ☐ Teeth are discolored and break easily
- ☐ Hives
- ☐ Eczema
- ☐ Muscle aches
- ☐ Joint pain or swelling
- ☐ Trouble with eyesight
- ☐ Wears glasses
- ☐ Wheezing

☐ **My teenager does not have any of these problems.**

g. Is your teenager taking any medications or vitamins now? ☐ No ☐ Yes

If yes, what is he/she taking? _____

_____

What illness/condition is he/she taking this for? _____

_____

Has your teenager ever used birth control that was prescribed by a doctor? ☐ No ☐ Yes

If yes, what kind? _____ For how long? _____

h. Who is your teenager's doctor? _____

In what town/city does the doctor have his/her practice? _____

i. What do you do when your teenager is acting up? _____

_____

_____

_____

_____

_____

Teenager's Name _____ Date of Birth _____

Family Medical History

Do any of your teenager's siblings, parents or grandparents suffer any of the following medical conditions? (Check all that apply and identify the family member affected by each illness)

- ☐ Anemia _____
- ☐ Asthma _____
- ☐ Delay in talking, moving around or understanding things _____
  _____
- ☐ Diabetes _____
- ☐ Drug/alcohol addiction _____
- ☐ Had a lot of broken bones _____
- ☐ Had a lot of discolored, broken or chipped teeth _____
- ☐ Heart disease _____
- ☐ HIV/AIDS _____
- ☐ Loss of hearing _____
- ☐ Mental retardation _____
- ☐ Nasal allergies _____
- ☐ Nosebleeds; bruises easily _____
- ☐ Psychiatric or mental illness _____
- ☐ Seizures _____
- ☐ Does anyone in your household smoke? _____
- ☐ Other (please list) _____

☐ **No one in my family has any of these illnesses.**

School Attendance

a. Please give the name and location of the school your teenager attends: _____
   _____
b. Which grade is your teenager in? _____
c. How is your teenager doing in school? ☐ Excellent ☐ Good ☐ Average ☐ Failing
d. If your teenager is failing at school, what is the problem? _____
   _____
   _____
   _____
   _____

Teenager's Name _____ Date of Birth _____

Social History

a. Please list all adults and children currently living in same home as your teenager and their relationship to your teenager:_____
_____
_____
_____

b. Has your family had any previous involvement with DSS? ☐ No ☐ Yes
If yes, please list the year and reason for involvement: _____
_____
_____
_____
_____

c. Has your child ever been around domestic violence? ☐ No ☐ Yes

Additional Comments by Healthcare Provider:

Questionnaire reviewed by: _____**Review Date** _____
Healthcare Provider