Medical Questionnaire
Ages 13 and Above

Teenager Name_________________________________Date of Birth ____________________
Questionnaire filled out by ____
Relationship to child ____
Date of visit ____

1. 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.**

2. 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 ____

3. 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 _________________________________

4. Does your teenager have any allergies to food or medications? ☐ No ☐ Yes
   If yes, please list ____
   ____
   ____

5. Are your teenager's immunizations up to date? ☐ No ☐ Yes
   If no, which are pending? ____

Teenager's Name ____Date of Birth _____________

6. 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.**

7. 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? _________________

8. Who is your teenager's doctor? ____
   In what town/city does the doctor have his/her practice? _______________________

9. What do you do when your teenager is acting up? _______________________________
   ____
   ____

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 ____

Teenager's Name ____Date of Birth _____________

- ☐ 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? ______________________
____
____
____
____
____

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