Community Health Care

Confidential Adolescent Health Inventory
(13-18 Yrs.)
Please complete both sides

Date: _____ **DOB:** _____ **Age:** _____ **Name:** _____

Gender preference: ☐ **Male** ☐ **Female** ☐ **Other:** _____ **Preferred Name:** _____

Preferred Pronoun: _____

****Please bring in a record of your immunizations for us to copy. ****

Please ask your healthcare provider about any questions you do not understand

Personal Medical History

☐ Yes ☐ No Do you have any particular concerns today? If yes, please explain: _____

_____

☐ Yes ☐ No Do you have any ongoing major medical illnesses (like asthma, diabetes, etc.?) If yes, what? _____

_____

☐ Yes ☐ No Do you take any medicines (daily or as needed)? What? _____

_____

☐ Yes ☐ No Do you take any vitamins, supplements, "alternative" medicines, or therapies? What? _____

_____

☐ Yes ☐ No Do you have any reactions to medications or immunization? If yes, please explain: _____

_____

☐ Yes ☐ No Have you ever had a surgery or had to spend the night at the hospital? If yes, please explain: _____

_____

Family History

☐ Unknown/Adopted

Check any of the following problems your grandparents, parents, brothers, or sisters, have had, and state who:

	Who?		Who?
☐	Blood disease: _____	☐	Heart attack: _____
☐	Depression: _____	☐	Overweight: _____
☐	High blood pressure: _____	☐	Alcoholism: _____
☐	High cholesterol: _____	☐	Physical abuse: _____
☐	Suicide: _____	☐	Asthma: _____
☐	Child abuse: _____	☐	Convulsions: _____
☐	Allergies: _____	☐	Tuberculosis: _____
☐	Cancer: _____	☐	Drug abuse: _____
☐	Diabetes: _____	☐	Sexual abuse: _____

Preventive Health

Yes No

☐ ☐ Do you smoke, use tobacco products, snuff, or smokeless products (vape)? If yes, what kind and how often?

_____

☐ ☐ Do you wear a seatbelt in the car?

☐ ☐ Do you always use a helmet when riding a bike, skateboarding, skiing, etc.?

☐ ☐ Are there smoke alarms, fire extinguishers and carbon monoxide alarms in your home?

(over)

Preventive Health (continued)

☐ ☐ Do you live with anyone that smokes? Who? _____

☐ ☐ Do you have a screen (computer, tablet, phone, TV, etc.) in your bedroom?

☐ ☐ Have you seen a dentist in the past 6 months?

☐ ☐ Do you brush your teeth daily?

☐ ☐ Have you had close contact with anyone who has tuberculosis (TB), or is at high risk for TB (anyone who has lived in a developing country, been institutionalized, homeless, IV drug user, HIV-positive)?

Education

Where do you go to school? _____ What grade are you in? _____

What your average grades? _____

☐ Yes ☐ No Do you have an Individualized Education Plan (IEP)/504 in place?

Social

Yes No

☐ ☐ Within the last 12 months, have you been exposed to a situation where threats, pushing, grabbing, hitting, kicking, breaking things or other hurting has been used?

☐ ☐ Within the last 12 months, have you experienced any uncomfortable touching? Forced sexual contacts?

☐ ☐ Who do you live with? _____

☐ ☐ Have you ever been on foster care?

Review of Systems *(Do you have any CURRENT problems that you'd like to discuss today?)*

Yes	No		What?	Yes	No		What?
☐	☐	vision problems	_____	☐	☐	skin problems	_____
☐	☐	breathing problems	_____	☐	☐	hearing problems	_____
☐	☐	problems moving your bowels (pooping)	_____	☐	☐	headaches, fainting, dizziness, any loss of consciousness	_____
☐	☐	stomach problems	_____				
☐	☐	urination (peeing) problems	_____	☐	☐	sleep difficulties, depression, anger, or nervousness	_____
☐	☐	body aches	_____				

Females Only

When was your first period? _____ When was the first day of your most recent period? _____

☐ Yes ☐ No Irregular periods, pain, or concerns about your periods? _____

Males Only

☐ Yes ☐ No Have you had any lumps in your testicles?

Other concerns: _____

_____

_____

_____

_____

For official use only

Reviewed by: _____ Date: _____

(over)