BridgeSpan Medicine
for teens and young adults
Affiliated with Boston Children's Hospital Physicians

ADOLESCENT HISTORY / *HISTORIA DEL PACIENTE*

Patient's Name / *Nombre del Paciente:* ____________________________________Date of Birth / *Fecha de Nacimiento:* __/__/__ Age / *Edad:* __

Parent / Guardian Name / *Padre O Garante:* ____ Relationship / *Relacion:* _________________

ADOLESCENT HEALTH HISTORY

Do you consider your child to be in good health? ☐Yes ☐No If no explain____

Does your adolescent have any allergies? ☐Yes ☐No If yes, what allergies? ____

Is your adolescent allergic to any medicines? ☐Yes ☐No If yes, what medicines? ____

Please provide the following information about medicines your adolescent is taking:

Name of medicine	Reason taken	How long taken
____________________________________	_____________________________	_______________________________
____________________________________	_____________________________	_______________________________
____________________________________	_____________________________	_______________________________

Does your child have any serious illnesses or medical conditions? ☐Yes ☐No
If yes explain:____

Has your adolescent ever been hospitalized? ☐Yes ☐No
If yes explain:____

Previous Surgeries and dates:
____

Please list any specialist your child is currently seeing and reason:
____

____

____

Please check whether your adolescent ever had any of the following health problems:
If yes, at what age did it start?

Condition	Yes	No	Age	Condition	Yes	No	Age
ADHD/learning disability	☐Yes	☐ No	Age: _____	Headaches/migraines	☐Yes	☐No	Age: _____
Allergies/hay fever	☐Yes	☐No	Age: _____	Low iron (anemia)	☐Yes	☐No	Age: _____
Asthma	☐Yes	☐No	Age: _____	Pneumonia	☐Yes	☐No	Age: _____
Bladder or kidney infections	☐Yes	☐No	Age: _____	Heart disease	☐Yes	☐No	Age: _____
Blood disorders/sickle cell anemia	☐Yes	☐No	Age: _____	Scoliosis (curved spine)	☐Yes	☐No	Age: _____
Cancer	☐Yes	☐No	Age: _____	Seizures / epilepsy	☐Yes	☐No	Age: _____
Chicken Pox	☐Yes	☐No	Age: _____	Severe acne	☐Yes	☐No	Age: _____
Depression	☐Yes	☐No	Age: _____	Stomach problems	☐Yes	☐No	Age: _____
Diabetes	☐Yes	☐No	Age: _____	Tuberculosis	☐Yes	☐No	Age: _____
Eating Disorder	☐Yes	☐No	Age: _____	Mononucleosis (mono)	☐Yes	☐No	Age: _____
Anxiety	☐Yes	☐No	Age: _____	Other: _________________________________			

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Household

What is the adolescent's living situation if not with both biological parents?

☐Lives with adoptive parents ☐Joint custody ☐ Single custody ☐Lives with foster family ☐N/A

Who currently lives in the house hold? ☐ Mom ☐ Dad ☐ Siblings (# _______) ☐ Grandparents ☐ Other ________________________________

If one or both parents are not living in the home, how often does your adolescent see the parent(s) not in the home?
____

Do any household members smoke? ☐Yes ☐No

Some health problems are passed from one generation to the next. Have you or any of your adolescent's blood relatives (parents, grandparents, aunts, uncles, brothers, or sister), living or deceased, had any of the following problems? If the answer is "Yes," please state the age of the person when the problem occurred and his or her relationship to your adolescent.

CONDITION	YES	NO	UNSURE	AGE AT ONSET	RELATIONSHIP
Allergies / Asthma	☐	☐	☐	__________	_________________
Anemia	☐	☐	☐	__________	_________________
Blood Disorder	☐	☐	☐	__________	_________________
Cancer	☐	☐	☐	__________	_________________
Heart Attack / Disease	☐	☐	☐	__________	_________________
High Cholesterol	☐	☐	☐	__________	_________________
High Blood Pressure	☐	☐	☐	__________	_________________
Stroke	☐	☐	☐	__________	_________________
Diabetes	☐	☐	☐	__________	_________________
Thyroid Disease	☐	☐	☐	__________	_________________
Kidney Disease	☐	☐	☐	__________	_________________
Seizures	☐	☐	☐	__________	_________________
Migraines	☐	☐	☐	__________	_________________
Depression / Anxiety	☐	☐	☐	__________	_________________
Alcoholism	☐	☐	☐	__________	_________________
ADD / ADHD	☐	☐	☐	__________	_________________
Other: ____________________________	☐	☐	☐	__________	_________________

Review of Systems *(Check all that Apply)*

Constitutional ☐ Fever/Chills ☐ Fatigue ☐ Unexplained weight loss/gain ☐ Excessive Thirst	**Gastrointenstinal** ☐ Nausea/Vomiting/Diarrhea ☐ Constipation/Blood in stool ☐ Abdominal Pain
Ear, Nose, and Throat ☐ Loud Voice/Hearing Problem ☐ Mouth-breathing/Smoking ☐ Ear Pain ☐ Frequent Runny Nose	**Cardiovascular** ☐ Chest Pain/Palpitations ☐ Tires easily with exertion ☐ Fainting
Respiratory ☐ Cough, short breath ☐ Chest tightness/Wheeze	**Genitourinary** ☐ Frequent or painful urination ☐ Bed Wetting frequent accidents ☐ Vaginal or Penile Discharge
Musculoskeletal ☐ Muscle pain/Weakness ☐ Joint Pain/Swelling ☐ Bone Pain	**Neurologic** ☐ Headaches ☐ Seizures ☐ Clumsiness ☐ Discharge
Other (Eye, Skin, Blood) ☐ Blurry Vision ☐ Squinting ☐ "Crossed eyes" ☐ Itchy eyes ☐ Rashes ☐ Abnormal moles ☐ Abnormal Bruising/Bleeding	**Psychiatric/Emotional** ☐ Anxiety/Stress ☐ Depression ☐ Sleep Problems ☐ Anger Concern ☐ Concerns with Attention/Impulsivity

Reviewed by: ____ Date: ____________________