Patient name: ________________ Patient DoB: ______

Parent/guardian name(s): ____________________

Parent/guardian signature: ____________________

Patient Health History Questionnaire (Ages 12-17)

Today's date: ________

Medications/supplements (include name and dosage): ____

____

Allergies to medications/food (include reaction): ____

Surgical/hospitalization history (include month/year): ____

Family History (specify relation for each)

- ○ Asthma ____________________
- ○ Autoimmune disease ____________________
- ○ Cancer (which type) ____________________
- ○ Diabetes ____________________
- ○ Heart disease before 55 ____________________
- ○ High cholesterol ____________________
- ○ Hypertension ____________________
- ○ Lung disease ____________________
- ○ Mental illness/depression ____________________
- ○ Migraine ____________________
- ○ Sudden cardiac death ____________________
- ○ Other: ____________________

Social History

Grade/School: ____________________

Parents relationship status: ____________________

Child adopted/in foster care? ☐ Yes ☐ No

Explain: ____________________

Names/ages of siblings: ____________________

Others in the home: ____________________

Sports: ____________________

Other interests: ____________________

Pediatrician (if not with AFM-A): ____________________

Vaccines up to date? ☐ Yes ☐ No

Alcohol use? ☐ Yes ☐ No If yes, how much? _____

Recreational drugs: ____________________

Any household members smoke? ☐ Yes ☐ No

Tobacco use? ☐ Current ☐ Former ☐ Never

Form? ☐ Cigarette ☐ Cigar ☐ Chew ☐ Vape

How much per day? ____________________

When did you quit? ____________________

Medical History Diagnosed by a Healthcare Provider

- ○ Allergies
- ○ Anxiety/depression
- ○ Arthritis
- ○ Asthma
- ○ Attention deficit disorder
- ○ Autism
- ○ Cancer (type) ______________
- ○ Congenital heart disease/surgery
- ○ Diabetes
- ○ GI problems
- ○ Head injury
- ○ Headaches
- ○ High cholesterol
- ○ Hypertension
- ○ Reading problems/dyslexia
- ○ Reflux disease (GERD)
- ○ Seizures
- ○ Stroke
- ○ Substance abuse
- ○ Thyroid problems
- ○ Vision problems
- ○ Other: ____

Provider initials: __________