KACHINA FAMILY MEDICINE ADOLESCENT MEDICAL HISTORY (10-17)

Personal Information

Full Name: ______________________________ Today's Date: __________
Last *First* *DOB* *Age*

Email: ______________________________ Preference for Rx: ☐ 30 day or ☐ 90 day supply

Pharmacy: ______________________________
Name & Cross Streets *Pharmacy Phone Number*

Current Medications: *Dose* *Times/day* *Dose* *Times/day*

1. ______________________ 3. ______________________
2. ______________________ 4. ______________________

Allergies to Medications & Reactions:

____

Medical History

☐Acne	☐Arthritis	☐Eating Disorder	☐Learning Disability	☐Cancer, Type:
☐ADD/ADHD	☐Asthma	☐GERD	☐Menstrual Disorder	
☐Allergies	☐Depression	☐Heart Disease	☐Migraines	☐Other:
☐Anemia	☐Developmental Disorder	☐Heart Murmur	☐Skin Disorder	
☐Anxiety	☐Diabetes Type: ☐ I ☐ II	☐Intestinal Disorder	☐Thyroid Disorder	

Surgeries*: (type and year)* ☐None ______________________________

____

OB/GYN: Have you ever been pregnant? ☐Yes ☐No

Lifestyle

Who do you live with? ____________________ Hobbies? ____________________

Pets? ____________ Years in AZ?_____ Previous states?____________________

Are you sexually active? ☐Yes ☐No ☐Not currently but have been in the past

Tobacco: ☐Yes ☐No ☐Former Years: _____ Type: ☐Cigarettes _____packs/day ☐Cigars ☐ECig/Vape

Alcohol: ☐Yes ☐No ☐Former Amount: _____ drinks per ☐day ☐week ☐month ☐year Drugs: ☐Yes ☐No ☐Former

Nutrition: ☐Excellent ☐Good ☐Average ☐Needs Improvement ☐Poor ☐Lots of Fast Food

Exercise: ☐None Types: ____________________ Frequency: For_____ minutes, ____days per week.

Family Medical History

☐ **ADOPTED (Skip to Preventative Care)**

Mother:		**Father:**		**Siblings:**	
☐Alive ☐Deceased Age: ______		☐Alive ☐Deceased Age: ______		Number of Brothers: _____ Sisters: _____	
Cause of death: ______		Cause of death: ______		Cause(s) of death: ______	
Medical Issues:		Medical Issues:		Medical Issues:	
☐ADD/ADHD	☐High Blood Pressure	☐ADD/ADHD	☐High Blood Pressure	☐ADD/ADHD	☐High Blood Pressure
☐Alcoholism	☐High Cholesterol	☐Alcoholism	☐High Cholesterol	☐Alcoholism	☐High Cholesterol
☐Anxiety	☐Kidney Disease	☐Anxiety	☐Kidney Disease	☐Anxiety	☐Kidney Disease
☐Asthma	☐Migraines	☐Asthma	☐Migraines	☐Asthma	☐Migraines
☐Depression	☐Obesity	☐Depression	☐Obesity	☐Depression	☐Obesity
☐Diabetes	☐Osteoporosis	☐Diabetes	☐Osteoporosis	☐Diabetes	☐Osteoporosis
☐Heart Disease	☐Other:	☐Heart Disease	☐Other:	☐Heart Disease	☐Other:
☐Cancer, Type:		☐Cancer, Type:		☐Cancer, Type:	

Preventative Care

Date of last Physical/Well Visit: ______________ Do you follow a standard vaccination schedule? ☐Yes ☐No

Date of last vaccination: Meningitis (Menactra)______________ HPV (Gardisil)______________

Tetanus/Pertussis (Tdap)______________ Influenza______________

PLEASE BRING A COPY OF YOUR SHOT RECORD TO YOUR APPOINTMENT

How did you hear about us? ______________________________

Signature of Parent/Guardian: ____________________ Date: __________ Relationship to Patient: __________