

Portland Family Practice- **Adolescent age 12 to 17**
PRE-VISIT SUMMARY

Dear patient or parent, thank you for completing this form. Please bring it with you to your appointment.

Patient's name: _____

DOB: _____

Visit date: _____

Reason for visit: _____

Do you have any concerns today? _____

Do you get good grades? _____

Do you like School? _____ What grade are you? _____

Repeat any grade? _____

Do you get along with your parents? _____ your siblings? _____

Are you social/ have friends? _____

Do you eat a balanced diet, from the four food groups? _____

Do you have or participate in any extracurricular activities? _____

Do you exercise? _____

How much time do you spend using the computer and/or watching TV daily? _____ Hours

Do you use your seat belt? _____ are there guns in your home? _____

Do you use any – cigarettes, alcohol or drugs/Marijuana? _____

Are you driving yet? _____

Have you ever had sex? _____

Females: age you started your period? _____ Any problems? _____

Current Medication(s), including vitamins, supplements/herbs –dose and quantity:

Medical History: Have you (or your child) had any of these problems..... Diabetes - Cancer
– Asthma – Bowel or Urinary problems -Psychiatric Disorder/Depression/Anxiety – Bleeding
Disorder – Thyroid Disease - Kidney Disease – skin problems – motor or speech problems
ADD/ADHD - Other:

Allergies to Medications: _____ **Other:** _____

Surgical History and dates: _____

Hospitalizations and dates: _____

FAMILY HISTORY:	Father	Mother	Siblings	Extended Family
DATE OF BIRTH				
Alive or Deceased				
High Cholesterol				
Coronary Disease				
Hypertension				
Diabetes				
Cancer				
Stroke				
Thyroid Disease				
Kidney disease				
Bleeding disorder				
Substance Abuse				
Depression				
Psychiatric Disorder				
OTHER Diseases not listed:				

Social/Habit History:

Travel outside US? NO _____ Yes = where? _____
 Do you use a smoke detector in your home? Yes _____ No _____
 Do you have pets? _____
 Do you feel safe? _____

Vaccination history:

Date of last tetanus /Adacel? _____ TB /PPD? _____
 Date of Gardasil/HPV? _____
 Meningococcal (Menactra or Menamune)? _____
 Date of Hepatitis B ? _____ Hepatitis A? _____

Name/location of the pharmacy you use the most? _____

CLINIC USE ONLY

Vitals: WT _____ HT _____ HC _____ BP _____ 2nd BP _____
 Pulse _____ T _____ R _____ HR _____ O2 sat _____
 Vision _____ corrected _____
 BP supine _____ sitting _____ standing _____
 HR supine _____ sitting _____ standing _____