

1. Last Name First Name MI

2. Patient Number

3. Date of Birth Month Day Year

4. Race  1. White  2. Black/African American  
 3. American Indian/Alaska Native  4. Asian  
 5. Native Hawaiian/Other Pacific Islander  6. Other  
 Ethnicity: Hispanic/Latino Origin?  Yes  No

5. Gender  1. Male  2. Female

6. County of Residence

**ADOLESCENT BASIC HISTORY**  
**11 to 21 Years**

7. English Speaking?  Yes  No Language Spoken: \_\_\_\_\_

8. Interpreter?  Yes  No Who? \_\_\_\_\_

9. Allergies: (food, drugs, insects, environment)

10. DATE 11. SOURCE OF INFORMATION  Patient  Other (specify) 12. RELATIONSHIP

13. FAMILY HISTORY

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Overweight/Obesity	<input type="checkbox"/> Childhood Blindness	<input type="checkbox"/> Physical/Sexual Abuse
<input type="checkbox"/> Lung Disease/ TB	<input type="checkbox"/> Kidney/ Urinary Disease	<input type="checkbox"/> Childhood Deafness	<input type="checkbox"/> Genetic Disorder
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Emotional Illness	<input type="checkbox"/> Birth Defects
<input type="checkbox"/> Heart Disease/Hypertension/ Stroke	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Suicide Attempt	<input type="checkbox"/> Mental Retardation
<input type="checkbox"/> Allergies/Asthma	<input type="checkbox"/> Allergies/Asthma	<input type="checkbox"/> Alcohol/Substance Abuse	<input type="checkbox"/> Dev. Disability

Detail Positive Findings	Annual History Update	Update Positive Findings

14. CHILDHOOD MEDICAL HISTORY

Delivery: Full term?  Yes  No  Unknown If No:  Earlier Than Expected  Later Than Expected

Were there any problems at delivery that caused this patient to have health or developmental problems?  Yes  No If yes, explain:

15. DENTAL CARE  Yes  No If yes, provider name: \_\_\_\_\_

16. INFECTIOUS DISEASES	Annual Update	Detail Positive Findings
<input type="checkbox"/> Rubella <input type="checkbox"/> Tetanus		
<input type="checkbox"/> Measles <input type="checkbox"/> Meningitis		
<input type="checkbox"/> Pertussis <input type="checkbox"/> STD		
<input type="checkbox"/> Chicken Pox <input type="checkbox"/> HIV/AIDS		
<input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Immune Suppression		
<input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Other		

17. SERIOUS ILLNESSES; ACCIDENTS; HOSPITALIZATIONS, SURGERIES (Dates and Outcomes)	Annual Update	Detail Positive Findings

18. SIGNATURE/INITIALS SIGNATURE/INITIALS SIGNATURE/INITIALS

\_\_\_\_\_  
 Patient Name, #, or DOB  
 or  
 Attach Patient Label Here

## ADOLESCENT BASIC HEALTH RISK ASSESSMENT 11 to 21 Years

<b>19. ASTHMA TRIGGERS</b>		<b>Annual Update</b>	<b>Annual Update</b>
a. Coughs especially at night or after exercise; exposure to cold air; cigarette smoking?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Allergic reactions such as food, pollen, mold, dust, animal dander, feathers, cock roaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Chest tightness; Shortness of Breath; Wheezing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>20. SUBSTANCE ABUSE</b>	<b>Description (type, route)</b>	<b>Amt/Week</b>	<b>Annual Update</b>
a. Beer <input type="checkbox"/> Yes <input type="checkbox"/> No			
b. Wine; Wine Coolers <input type="checkbox"/> Yes <input type="checkbox"/> No			
c. Hard Liquor <input type="checkbox"/> Yes <input type="checkbox"/> No			
d. Prescription meds <input type="checkbox"/> Yes <input type="checkbox"/> No			
e. OTC meds <input type="checkbox"/> Yes <input type="checkbox"/> No			
f. Illicit Drugs <input type="checkbox"/> Yes <input type="checkbox"/> No			
g. Tobacco <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>21. PSYCHO-SOCIAL PROBLEMS</b>		<b>Annual Update</b>	<b>Annual Update</b>
a. Physical or Sexual Abuse/ Verbal Abuse/ Domestic Violence?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Other Emotional/ Family/ Social problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>22. REPRODUCTION:</b>			
<b>Female</b> Age at Menarche: _____	<b>Findings</b>	<b>Annual Update</b>	<b>Annual Update</b>
a. LNMP			
b. Last GYN and breast exam			
c. Menstrual pattern			
d. Menstrual problems			
e. Pregnancy/Abortion			
f. Last self breast exam			
g. Self breast exam taught			
<b>Male</b>	<b>Findings</b>	<b>Annual Update</b>	<b>Annual Update</b>
a. Number of children fathered			
b. Last self testicular exam			
c. Self testicular exam taught			
<b>Male and Female</b>	<b>Findings</b>	<b>Annual Update</b>	<b>Annual Update</b>
a. Sexual activity, age at first intercourse			
b. Number of partners			
c. Concern about pregnancy			
d. Contraception			
e. Genetics: Sickle Cell status			
<b>SIGNATURE or INITIALS / DATE</b>	/	/	/
<b>23. DIETARY SCREENING/ ACTIVITY SCREENING</b>	<b>11 to 13 years</b>	<b>13 to 16 years</b>	<b>16 to 21 years</b>
a. # times a day eats snacks?/ Snack type?			
b. Fast foods/ # times per day?			
c. Satisfaction with current weight?			
d. Predominant beverage?			
e. Daily consumption of cheese, yogurt, milk? Amt./day			
f. Special diets or changes in eating pattern/ food choices?			
g. Concerns/ questions about eating, diet, weight, other?			
h. Takes vitamin or other nutrient/ herbal/ supplements?			
i. Daily consumption of fruits/ vegetables? Amt./day			
j. Daily consumption of meat alternates? Amt./day			
k. Physically active for 60 minutes/day at least 5 days/week?			
<b>SIGNATURE OR INITIALS/DATE</b>	/	/	/

\*\*Positive findings on basic health risk assessment indicate the need for annual health screenings

## ADOLESCENT BASIC HISTORY (DHHS 2816)

- 1.-6. NAME, NUMBER, ETC. In the blank space in the top left on the front, attach the computer generated label or emboss the information imprinted on the patient's identification card or manually record the patient's name (last name, first name, and middle initial), identification number, date of birth (MM-DD-YY), race, gender, and county of residence.
7. ENGLISH SPEAKING Check "Yes" or "No" as appropriate. If "No", record the language spoken.
8. INTERPRETER Check "Yes" or "No" as appropriate. If "Yes", record who is providing interpretation.
9. ALLERGIES List all of patient's allergies: food, drugs, insects, environment. Record in red ink if possible.
10. DATE Record the date the initial history is taken.
11. SOURCE OF INFORMATION Check "Patient" when information is provided by the patient. Check "Other" when a parent or someone else is the informant. Specify the name of the informant. Indicate when both contributed significantly and include the quality of the information provided, (ie. poor historian, good historian, not sure of details, etc).
12. RELATIONSHIP Specify the relationship of the informant to the patient.
13. FAMILY HISTORY Indicate by "X" presence of any of these problems in patient or close relative(s). Indicate by "O" the absence of any of these problems in this same group. Detail positive findings. Information recorded on previously completed history forms may be referenced here. Update at subsequent well care visits. At the time of the update if no new findings are found, enter date and sign. **Family history is to be updated annually with any positive findings noted.**
14. CHILDHOOD MEDICAL HISTORY Record broad, general review of the perinatal period from information provided. Record problems at delivery that may have caused the patient to have any health or developmental problems.
15. DENTAL CARE Check "Yes" or "No" as appropriate. If "Yes", indicate where patient receives dental care.
16. INFECTIOUS DISEASES Indicate by "X" if patient has had disease. Indicate by "O" if patient has not had disease. **Update annually, noting any positive findings.**

## DHHS 2816 (cont)

- |     |  |   |
|-----|--|---|
| 17. | CHRONIC OR SERIOUS ILLNESS; INJURY; HOSPITALIZATION/ SURGERY | Record diagnosis, condition, or operation, date of occurrence and outcome. Detail when possible, whom and where care was given. <b>Update annually, noting any positive findings.</b> |
| 18. | SIGNATURE/INITIALS   | Record full legal signature or initials of health professional responsible for this information.  |

## ADOLESCENT BASIC RISK ASSESSMENT – 11 to 21 Years

- |     |                                       |  |
|-----|---------------------------------------|--|
| 19. | ASTHMA TRIGGERS                       | Check “Yes” or “No” as appropriate. <b>Update annually.</b>  |
| 20. | SUBSTANCE ABUSE                       | Record substance use/abuse information.<br>*Alcohol- Identify type or types used and average consumption.<br>*Drugs- Record drugs, Rx, OTC, or Illicit drugs.<br>*Tobacco-Record average number of packs of cigarettes, number of pipefuls, cigars or wads of chewing tobacco or dips of snuff. <b>Update annually.</b>                                  |
| 21. | PSYCHO-SOCIAL PROBLEMS                | Indicate “Yes” or “No” as appropriate. <b>Update annually.</b>   |
| 22. | REPRODUCTION                          | Female- Record age at menarche. Record onset of last normal menstrual period. Record findings as noted.<br><br>Male- Record findings as noted.<br><br>Male and Female- Record findings as noted. <b>Update section annually.</b><br><br>SIGNATURE OR INITIALS AND DATE- Record legal signature or initials of health professional obtaining information. |
| 23. | DIETARY SCREENING/ ACTIVITY SCREENING | Record findings as noted. <b>Update annually.</b>  |
|     | SIGNATURE OR INITIALS/DATE            | Record legal signature of health professional obtaining information.   |