Longs Peak Family Practice

New Patient Adolescent Medical History Form
12-17 years of Age

Patient Name: _____ Date: _____

D.O.B_____ Age_____ Male/Female

Please list any major medical problems and dates:

_____

Hospitalizations/Operations and dates: _____

_____

Date of last dental exam: _____ Date of last dilated eye exam:_____

Broken bones or severe injuries and dates: _____

Please list ALL medications**,** vitamins, herbs and supplements you presently take regularly or occasionally, prescription, and non-prescription. Include dose and frequency:

_____

_____

Are you allergic to any medications, supplements or vaccinations? Please list them plus your reaction:

_____

Are your vaccinations up to date? YES/NO Please provide vaccine record or sign a release of information form from the front desk requesting records from your previous doctor.

What illnesses/diseases run in your family?
Mother: _____
Father: _____
Siblings: _____
Other:_____

Please list your school and grade. _____
Please list any organized sports you play. _____
Please list any extra-curricular activities you do. _____