Adolescent's Name_____ Age_____ Birth Date_____ Date_____
Your Name_____ Relationship to Adolescent_____

ADOLESCENT HEALTH HISTORY

1. Is your adolescent allergic to any medicine?..... ☐ No ☐ Yes
   If yes, what?_____
2. List any medications your adolescent is taking now, and the problem for which the medication was given:_____
   _____
3. Has your adolescent ever been hospitalized overnight?..... ☐ No ☐ Yes
   If yes, please describe_____
4. Has there been any change in your adolescent's health during the past year?..... ☐ No ☐ Yes
   If yes, please describe_____

FAMILY HISTORY

1. With whom does the adolescent live with most of the time? **(Check all that apply)**
   - ☐ Both parents in the same household
   - ☐ Mother
   - ☐ Father
   - ☐ Stepmother
   - ☐ Stepfather
   - ☐ Guardian
   - ☐ Alone
   - ☐ Brother(s)/ages____
   - ☐ Sister(s)/ages_____
   - ☐ Other:_____
2. In the past year, have there been any changes in your family? **(Check all that apply)**
   - ☐ Marriage
   - ☐ Separation
   - ☐ Divorce
   - ☐ Serious Illness
   - ☐ Loss of a Job
   - ☐ Move to a new house
   - ☐ Change in school
   - ☐ Births
   - ☐ Deaths
   - ☐ Other:_____

PARENTAL/GUARDIAN CONCERNS:

Please review the topics listed below and check if this is a concern you are having about your son or daughter or if you would like to discuss this topic:

- ☐ Physical complaints
- ☐ Physical development
- ☐ Weight
- ☐ Change of appetite
- ☐ Sleep patterns
- ☐ Diet/Nutrition
- ☐ Amount of Physical Activity
- ☐ Emotional Development
- ☐ Relationship with family
- ☐ Choice of friends
- ☐ Self-image/Self worth
- ☐ Excessive moodiness/Rebellion
- ☐ Depression
- ☐ Lying/Stealing, or vandalism
- ☐ Violence
- ☐ School
- ☐ Grades/truancy/ dropout
- ☐ Smoking cigarettes
- ☐ Chewing tobacco
- ☐ Drug Use
- ☐ Alcohol use
- ☐ Dating/Parties
- ☐ Sexual Behaviors
- ☐ HIV/AIDS
- ☐ Birth control
- ☐ Sexual Identity (heterosexual, homosexual)
- ☐ Work or Job
- ☐ Other:_____

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QUESTIONS FOR PARENT/GUARDIANS

1. Over the past year, what have been your child's grades?_____
2. How many days of school has your child missed since the beginning of this school year?_____
3. Do you or another adult regularly supervise or keep track of your adolescent's activities?..... ☐ Yes ☐ No
4. Does your adolescent have a significant amount of unsupervised time each day, after school or in the evening?..... ☐ Yes ☐ No
5. How many hours per week does your child work outside the home? __0hrs __10hrs __20hrs __30hrs
6. Have you discussed with your adolescent his/her use of alcohol/tobacco, or other drugs?..... ☐ Yes ☐ No
7. Have you discussed with your adolescent his/her sexual orientation and sexual behavior?..... ☐ Yes ☐ No
8. Have you discussed with your adolescent safe driving as a passenger and as a driver?..... ☐ Yes ☐ No
9. Is there a gun in your household?..... ☐ No ☐ Yes
   If **yes**, is it secured/locked with ammunition stored separately?..... ☐ Yes ☐ No
10. Do you involve your adolescent in decisions about his/her health?..... ☐ Yes ☐ No
11. What do you and your adolescent do together on a regular basis (for example, have meals together)?

    _____

    _____
12. Do you have any additional questions or concerns?..... ☐ No ☐ Yes

    _____

    _____

PARENT AND GUARDIAN CHALLENGES

Health life styles and preventing measures should be part of everyone's daily routine. Your decisions about alcohol and other drugs, smoking, food choices, safety, and physical activity can strongly influence your adolescent's behavior and decisions. Parent/guardians demonstrate by their action what they believe or value.