Doctors Care
Accessible Care for the Underserved

TEEN/ADULT HEALTH HISTORY
13 TO 50 YEARS

Patient Name: _____ DOB: _____

1. Have you had any serious illnesses, accidents or been hospitalized? _____Y _____N
   If yes, what or what for?
   _____
2. When was your last tetanus booster? _____
3. Do you have any allergies to medications? _____
4. Are you currently taking any medications? Please list_____
5. Do your brothers, sisters, parents or grandparents have any of the following:
   Allergies _____ asthma_____ birth defects_____ diabetes_____ thyroid problems_____ cancer_____
   death under age 50 from heart attack_____ high blood pressure_____ seizures_____
   alcohol problems_____ drug-related problems_____ mental illness_____ physical handicaps_____
   tuberculosis_____ hepatitis_____
6. Do you or anyone in your house smoke? _____Y _____N
7. Have you or anyone in your household ever been sexually or physically abused? _____Y _____N
8. Do you have any of the following problems or issues?
   Acne_____ HIV/AIDS_____ vision problems_____ school problems_____
   family problems_____ body development_____ weight gain_____ dental problems_____
   sexuality issues_____
9. Do you have anything you would like to discuss with the provider in private?
   _____
10. If you are been seen today for an illness, what would you have done if the clinic was not in existence?
    a. Gone to another physician
    b. Gone to the emergency room
    c. Gone to another walk-in clinic
    d. Waited as long as possible, until the situation was an emergency
    e. Done nothing due to inability to pay

Parent Signature _____ Date: _____

P.A. or M.D. Signature _____ Date: _____

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