

**Lamprey Health Care
Title X Program**

Teen Clinic Medical History Questionnaire

Today's Date ____/____/____

Your name _____ Date of Birth ____/____/____

What hospitalizations/operations have you had ? _____

For what conditions do you see the doctor more than once year ? _____

What medicines do you take more than once a month (including Aspirin, Tylenol, laxatives, birth control pills, vitamins, etc.)? _____

Do you have any medication allergies ? [] Yes [] No Explain: _____

What was the date of your last immunization for: Measles, Mumps and Rubella (MMR) ____/____/____

Rubella ____/____/____ Hepatitis B ____/____/____ Tetanus ____/____/____ HPV ____/____/____

Did your mother take the drug DES when she was pregnant ____yes ____no ____ I don't know

Please check the boxes below that fit your family medical history to the best of your knowledge.

	Myself	Mother	Father	Sister	Brother	Mother's	Father's	Child	Other	None		Myself	Mother	Father	Sister	Brother	Mother's	Father's	Child	Other	None	
High Blood Pressure											Kidney Failure											
Heart Problem (before age 50 yrs)											Stroke											
Heart Problem (after age 50 yrs)											Diabetes											
Colon/Rectal Cancer											Breast Cancer											
Seizures/Epilepsy											Cancer (other types)											
Migraine Headaches																						

TURN OVER AND COMPLETE OTHER SIDE

FOR LAMPREY HEALTH CARE USE ONLY

Reviewed by : _____ Date : _____

Birth Control

Are you interested in a birth control method today? No Yes What method _____

Are you and your partner(s) currently using a method of birth control? No Yes

What method _____ Any problems? _____

Have you used other methods in the past No Yes
What method _____ Any problems? _____

Have you had intercourse without birth control since your last menstrual period? No Yes

Women's Health History

The first day of your last menstrual period : ___/___/___ Was it? Normal Not normal

Age at which you had your first period _____ Years. Are you still having periods? No Yes

Do your periods come every month? No Yes \How many days do they last _____

Number of pads/tampons you user per day when your flow is heaviest _____

Do you bleed between periods? No Yes Do you bleed after sex? No Yes

Do you have bad cramps? No Yes Any questions about your periods? No Yes

Have you ever had a pap smear? No Yes when was the last one? _____

Have you ever had an abnormal pap? No Yes When _____

When was the last one? _____

Have you been abused, physically, mentally or sexually in the past? No Yes

Have you ever been pregnant No Yes

Patient Signature: _____ Date: _____

FOR LAMPREY HEALTH CARE USE ONLY

REVIEWED BY:

DATE: