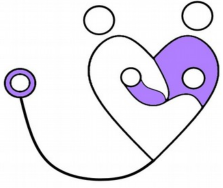

Cheryl Newman M.D.
Family Medicine

Adolescent History

2550 Baird Road
Penfield, NY 14526
585-395-1111
585-395-1116 (fax)
www.cherylnewmanmd.com

Name_______________________________________ Age:_________ D.O.B. ___/___/___

Most recent Primary Care Provider:____

Please list any concerns you want to discuss with Dr. Newman at your appt.

Health History

Please list your current or previous medical problems:

Please list ALL of the medications you take:
(Please include prescription drugs, home remedies, over-the-counter medications, allergy or cold pills, laxatives, and vitamins. If you do not have enough room, please use another sheet of paper.)

Name Dose (mg or # of pills) How many times a day?

Are you allergic to any medications? ______________________ Reaction?____________________

Are you allergic to anything else? ____

Please list all of the other doctors you have seen. Please include dentists, eye doctors, chiropractors, specialists, counselors, podiatrists, acupuncturists, etc.

Please list all surgeries, hospitalizations and procedures.

Problem	Surgery	Date	Doctor	Hospital

Have you ever had a head injury? **Y N Age:**
Have you ever fainted or been knocked out? **Y N Age**
Have you ever broken a bone? **Y N Age:**

Do you have problems with, or concerns about: (Circle)

Height/Weight	Headaches	Dizziness	Vision	Hearing
Allergies	Chest Pain	Trouble breathing	Cough	
Breasts	Stomach Pain	Nausea/Vomiting	Diet/Food/Appetite	
Skin(Rash, Acne)	Heart	Painful Urination	Wetting the bed	
Dying	Genitals/ Sex	Sleep/ Tiredness	Menstruation/ Periods	
Cancer	Diarrhea	Constipation	Muscle or joint pain	

Other:____
_

Family History

Are you adopted? Y N

Parents:
Mother: birth year _________ Medical problems:____
Alive? Y N Cause of death:_____________________ Age (now or at death) _____

Father: birth year _________ Medical problems:____
Alive? Y N Cause of death: ______________________ Age (now or at death) _____

Siblings: None________
Please list **siblings**, along with their **birth year**, any **medical problems** (and if deceased, their age at that time)

Grandparents:

Mother's Mother: birth year ________ Medical problems:___________________________
Alive? Y N Cause of death:____________________ Age (now or at death) _____

Mother's Father: birth year ________ Medical problems:___________________________
Alive? Y N Cause of death:____________________ Age (now or at death) _____

Father's Mother: birth year ________ Medical problems:___________________________
Alive? Y N Cause of death:____________________ Age (now or at death) _____

Father's Father: birth year ________ Medical problems:___________________________
Alive? Y N Cause of death:____________________ Age (now or at death) _____

Habits

How often does your family eat fast food? _____________________________________
Are you on a special diet? _________________________________
Over the past year have you tried to control your weight by vomiting, taking diet pill, taking laxatives or starving yourself? Y N ___________________________________
Does anyone smoke in your home? ____
Are there guns, rifles or other firearms in the house?________________________
Do you have a television in your bedroom? __________________________
What grade are you in?______________________________
Are you disabled? Y N If yes, by what?____________________________________
Have you ever used tobacco? _____________
If Yes: Do you use tobacco now? __________ If not, quit date? ____________
How long have/had you smoked for? ______________
How much per day? ______________
Which type? ( ) Cigarettes ( ) Cigars ( ) Pipe ( ) Chew Other _________
How many alcoholic beverages do you consume weekly? _____________
How much caffeine do you drink?
Coffee ______ cups/day Tea______ per/day Soft drinks______ per day

Life / Situational History

Birth Place:____
Where did you grow up:____
What is your Religion: ____
Parents Marital Status: [ ] Single [ ] Married [ ] Partnered [ ] Divorced
[ ]Widowed [ ] Separated

Please list *everyone* living in your household:

Name	Relationship (if any)	Age	Occupation

Signature: _______________________________________ Date: ________________________