Patient name: _____ Patient DoB: _____

Parent/guardian name(s): _____

Parent/guardian Signature: _____ Date:

Patient Health History Questionnaire (Ages 12-17)

Medications/supplements (include name and dosage): _____

_____

Allergies to medications/food (include reaction): _____

Surgical/hospitalization history (include month/year): _____

Family History (specify relation for each)

- ☐ Asthma _____
- ☐ Autoimmune disease _____
- ☐ Cancer (which type) _____
- ☐ Diabetes _____
- ☐ Heart disease before 55 _____
- ☐ High cholesterol _____
- ☐ Hypertension _____
- ☐ Lung disease _____
- ☐ Mental illness/depression _____
- ☐ Migraine _____
- ☐ Sudden cardiac death _____
- ☐ Other: _____

Social History

Grade/School: _____

Parents relationship status: _____

Child adopted/in foster care? ☐ Yes ☐ No

Explain: _____

Names/ages of siblings: _____

Others in the home: _____

Sports: _____

Other interests: _____

Pediatrician (if not with Arete): _____

Vaccines up to date? ☐ Yes ☐ No

Alcohol use? ☐ Yes ☐ No If yes, how much? ____

Recreational drugs: _____

Any household members smoke? ☐ Yes ☐ No

Tobacco use? ☐ Current ☐ Former ☐ Never

Form? ☐ Cigarette ☐ Cigar ☐ Chew ☐ Vape

How much per day? _____

When did you quit? _____

Medical History Diagnosed by a Healthcare Provider

- ☐ Allergies
- ☐ Anxiety/depression
- ☐ Arthritis
- ☐ Asthma
- ☐ Attention deficit disorder
- ☐ Autism
- ☐ Cancer (type) _____
- ☐ Congenital heart disease/surgery
- ☐ Diabetes
- ☐ GI problems
- ☐ Head injury
- ☐ Headaches
- ☐ High cholesterol
- ☐ Hypertension
- ☐ Reading problems/dyslexia
- ☐ Reflux disease (GERD)
- ☐ Seizures
- ☐ Stroke
- ☐ Substance abuse
- ☐ Thyroid problems
- ☐ Vision problems
- ☐ Other: _____