TEXAS DEPARTMENT OF HEALTH
ADOLESCENT INITIAL HISTORY FORM
(11-21 YEARS)

Today's Date: _____

NAME: _____
DOB: ___/___/___ SEX: _____
SSN/RECORD #: _____
RACE/ETHNICITY: _____
Medical Home: _____
Insurance: _____

**Please answer all questions on this form in reference to the teenage patient.

- Home phone #: _____ Work Phone # _____
- Permanent Contact Name: _____ Relationship: _____ Phone #: _____
- If needed, can we call your home & leave message for you saying "the clinic called? ☐ Yes ☐ No
- Who brought you to clinic today? _____
- Are you in school? ☐ Yes ☐ No Name: _____ Grade _____
- Do you have a job? If so, where do you work? _____

Medical History:

1. Do you have any health problems? ..... ☐ Yes ☐ No
Problems: _____

2. Have you ever been hospitalized for an illness or had an operation? ..... ☐ Yes ☐ No
If yes, give age and explain the reason for hospitalization or operation:
Age _____ Reason: _____
Age _____ Reason: _____
Age _____ Reason: _____

3. Have you had any serious injuries? ..... ☐ Yes ☐ No
If yes, give age and describe the injury:
Age _____ Injury: _____
Age _____ Injury: _____

4. Do you take any medications regularly? ..... ☐ Yes ☐ No

Medication	How long	Reason

5. Do you have any allergies to medicines? ..... ☐ Yes ☐ No
Name of medicine: _____ Type of reaction: _____
Name of medicine: _____ Type of reaction: _____

6. If you ever had any of the following problems, please write how old you were when it started:

	Yes	No	Age		Yes	No	Age
Acne	☐	☐	____	Depression	☐	☐	____
Asthma	☐	☐	____	Emotional problems	☐	☐	____
Bladder infection	☐	☐	____	Learning problems	☐	☐	____
Tuberculosis	☐	☐	____	Sickle cell anemia or trait	☐	☐	____
Chicken pox	☐	☐	____	Stomach ulcer	☐	☐	____
Mononucleosis	☐	☐	____	Heart disease	☐	☐	____
Hepatitis	☐	☐	____	Diabetes	☐	☐	____
STD's	☐	☐	____	Thyroid	☐	☐	____
Headaches	☐	☐	____	Cancer	☐	☐	____
Seizures/epilepsy	☐	☐	____	Scoliosis/back problems	☐	☐	____
Vision	☐	☐	____	Other: _____	☐	☐	____
Hearing problems	☐	☐	____	Other: _____	☐	☐	____

*** PLEASE TURN OVER ***

7. Specific Health Concerns:

Please check below if you have any questions or concerns about any of the following:

☐ Height	☐ Chest pain	☐ Learning or school problems
☐ Blood pressure	☐ Coughing/wheezing	☐ Muscle or joint pain
☐ Acne	☐ Wetting the bed	☐ Cancer
☐ Breasts	☐ Frequent or painful urination	☐ Dying
☐ Heart	☐ Headaches	☐ Menstruation/periods
☐ Appetite	☐ Trouble sleeping	☐ Pregnancy
☐ Stomach pain	☐ Tiredness	☐ Sexual organs/genitals
☐ Nausea/vomiting	☐ Vision problems	☐ Physical or sexual abuse
☐ Diarrhea/constipation	☐ Hearing problems	☐ Other: _____

8. Family Information:

Please check if anyone in your family (including grandparents, aunts, uncles, cousins, etc.) Have or had any of the following problems:

Yes	No	Relationship	Yes	No	Relationship
☐	☐ Cancer	_____	☐	☐ Drug abuse	_____
☐	☐ Heart attack (<55 yrs)	_____	☐	☐ Mental illness	_____
☐	☐ High blood pressure	_____	☐	☐ Learning problems	_____
☐	☐ Diabetes	_____	☐	☐ Tuberculosis	_____
☐	☐ Alcoholic	_____	☐	☐ Stroke	_____

9. With whom do you live? _____

Do you have any family problems? ☐ Yes ☐ No

If yes, explain: _____

10. During the past year have there been any of the following changes in your family:

☐ Marriage ☐ Serious illness ☐ Births ☐ Deaths

☐ Separation ☐ Divorce ☐ Loss of job ☐ Other: _____

11. Patient's father/guardian's job: _____ **Patient's mother/guardian's job:** _____

12. Have you ever lived away from home? ☐ Yes ☐ No

If yes, explain: _____

13. Form filled out by: ☐ patient ☐ guardian/parent ☐ other:

For 12 yrs and up: CRAAFT SCREENING TEST *(99420)*

Parents, please let your teen fill this section themselves.

1. Have you ever ridden in a car driven by someone (including yourself) who was high or had been using alcohol or drugs?.....YES NO
2. Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in?.....YES NO
3. Do you ever use alcohol or drugs while you are by yourself, alone?.....YES NO
4. Do you ever forget things you did while using alcohol or drugs?.....YES NO
5. Do your family or friends ever tell you that you should cut down on your drinking or drug use?.....YES NO
6. Have you ever gotten into trouble while you were using alcohol or drugs?.....YES NO