

**K+STAT URGENT CARE Adolescent Medical History (Ages 12-17)**

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**REASON FOR TODAY’S VISIT:** \_\_\_\_\_

Is the child allergic to any medications? Yes No (If yes, what?) \_\_\_\_\_

List any medications/supplements the child is currently taking \_\_\_\_\_  
**(PLEASE LIST DOSAGE AND FREQUENCY OF MEDICATION)**

**IMMUNIZATIONS**

Are the child’s immunizations up to date? Yes No

Date of last Tetanus Vaccine (DTaP/Tdap/Td) \_\_\_\_\_ Date of last Flu Vaccine \_\_\_\_\_

**PAST MEDICAL HISTORY**

Has the patient ever been hospitalized overnight? Yes No  
(If yes, explain) \_\_\_\_\_

Has the patient ever had any serious injuries? Yes No  
(If yes, explain) \_\_\_\_\_

Has the patient ever had any of the following illness or problems? *(Please circle all that apply)*

- |                          |            |                   |               |
|--------------------------|------------|-------------------|---------------|
| Allergies                | Anemia     | Asthma            | Mononucleosis |
| Cancer                   | Diabetes   | Seizures/Epilepsy | Heart Disease |
| Scoliosis (curved spine) | Depression | ADD/ADHD          | Other: _____  |

**SOCIAL HISTORY**

With whom does patient live with? *(Please circle all that apply)*

Both parents in same household Mother Father Guardian Grandparents Brothers Sisters

List the patient’s school/occupation: \_\_\_\_\_

Does the patient smoke, drink alcohol, and/or take drugs? Yes No (If yes, explain) \_\_\_\_\_

**FAMILY HISTORY**

Is there a family history, among blood relatives, of the following? *(Please circle all that apply)*

- |          |                     |                        |                                   |
|----------|---------------------|------------------------|-----------------------------------|
| Asthma   | High Blood Pressure | Cancer                 | Sickle Cell Anemia                |
| Diabetes | High Cholesterol    | Tuberculosis (TB)      | Heart Attack/Stroke before age 55 |
| Smoking  | Alcohol/Drug Abuse  | Psychological Problems | Other: _____                      |

**Parent / Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_