BETHEL Health Center
A home for health and wellness

Youth Health History

Date: _____

Patient's Name: _____ Name of Doctor: _____Last Visit_____

Date of Birth: _____ Name of Dentist: _____Last Visit_____

Allergy to Medication (s)? _____

Reason for today's visit? _____

	Has this patient had any of the following conditions? *(check all that apply)*
	Vision problems?
	Allergies? (Other than medication, e.g. peanuts)
	Asthma? (Chronic wheeze or cough)
	Chest pain with exercise?
	Frequent headaches?
	Frequent infections? (Ear, throat, or lung infections)
	Missing or damaged organs? (Eye, kidney, testicle)
	Hearing problems?
	Problems with bowel movements?
	Learning or developmental problems?
	Heart or blood pressure problems?
	Serious accidents? Head trauma, concussion, or loss of consciousness?
	Serious dental problems?
	Depression
	Anxiety
	Sleep Problems
	Serious or chronic illness such as diabetes, cancer, seizure?
	Currently taking medication
	Surgeries?
	Urinary tract infection, kidney problems, bedwetting?
	Sexually Active
	Victim of physical or sexual abuse?
	Other _____
Please explain any items checked:	

Social History					
Patient lives with : (check all that apply)					
	Mother		Father		Other: _____
Who has legal custody of patient?					
Was this patient ever in foster care?					
In the past year, have there been any changes in your family? (check all that apply)					
	Separation		Loss of job		
	Divorce		Change to new school		
	Birth		Serious illness		
Other changes/stresses?					

Habits: (check all that apply)

☐ Caffeine ☐ Tobacco ☐ Alcohol ☐ Recreational Drugs

☐ 30 minutes of exercise most days

☐ 5 servings of fruits & vegetables most days

	Do members of the patient's family have any of the following?
	Please explain who in the family next to the health issue (mother, father, sister, brother, aunt, uncle, grandparent):
	Alcohol or drug use?
	Allergies?
	Asthma?
	Blood problems?
	Diabetes?
	Death (at age 45 or younger)
	Heart problems?
	High blood pressure?
	Mental Illness?
	Obesity?
	Seizures?
	Other?

Well Child/Annual Exam		
Has the patient had one in the past year?	**Y**	**N**
If yes, where?		
If no, are you interested in scheduling one at the Bethel Health Center?	**Y**	**N**