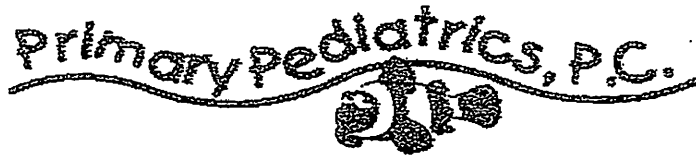
11 yr. and older



Middle-Older Adolescent Update Sheet

Name: ______________________________ Date of Birth: ______________

Current Medications: ____

Allergies: ____

Medical History:

Recent Surgeries/Hospitalizations (Dates/Reasons): ______________________

____

Social History:

Tobacco:

Do you every smoke cigarettes/cigars, use snuff or chew tobacco?

_____Yes _____No

Alcohol:

In the past, have you ever gotten drunk drinking beer, wine or any other alcohol?

_____Yes _____No

Drugs:

Do you ever use marijuana or other drugs or sniff inhalants?

_____Yes _____No

Do you ever use no-prescription drugs to get to sleep, stay awake, calm down or get high?

_____Yes _____No

Developmental:

Have you ever had sexual intercourse?

_____Yes _____No

Are you using methods to prevent pregnancy/sexually transmitted diseases?

_____Yes _____No

Have you ever been told by a doctor or a nurse that you had a sexually transmitted infection (STI) or disease (STD)?

_____Yes _____No

Have you ever been pregnant or gotten someone pregnant?

_____Yes _____No

Do you have any topics you would like to discuss with the doctor today? Please list them.