**Health History (Age: 13+ yrs)**

Intake

Name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social History:

Please check appropriate box and/or answer questions to the best of your ability.

1. Diet: \_\_\_Regular \_\_\_Vegetarian \_\_\_Vegan \_\_\_Gluten Free

 \_\_\_Other Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Exercise Level: \_\_\_None \_\_\_Occasional \_\_\_Moderate \_\_\_Heavy
2. Sporting Activities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Parents’ Marital Status: \_\_\_Married \_\_\_Unmarried \_\_\_Separated \_\_\_Divorced \_\_\_Widowed
4. Home Situation: \_\_\_Both Parents \_\_\_Mother \_\_\_Father \_\_\_Relatives \_\_\_Adoptive Parents \_\_\_Foster Parents \_\_\_Other Please Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Siblings: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Animal Exposure: \_\_\_Yes \_\_\_No
7. Passive Smoke Exposure \_\_\_Yes \_\_\_No
8. Seat belt/Car seat used routinely: \_\_\_Yes \_\_\_No
9. Sunscreen used routinely: \_\_\_Yes \_\_\_No
10. Guns present in home: \_\_\_Yes \_\_\_No
11. Year in School (current grade): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
12. Smoke Alarm in home: \_\_\_Yes \_\_\_No
13. Alcohol Intake: \_\_\_Never \_\_\_Occasional \_\_\_Moderate \_\_\_Heavy
14. Smoking Status: \_\_\_Never Smoker \_\_\_Former Smoker \_\_\_Current Every Day Smoker \_\_\_Current Some Day Smoker
15. If smoker, How Much: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
16. Illicit Drugs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
17. Sexually Active: \_\_\_Yes \_\_\_No
18. Sexual Orientation: \_\_\_Heterosexual \_\_\_Homosexual \_\_\_Bisexual
19. Protected Sex: \_\_\_Yes \_\_\_No