

We would like to ask you a few more questions to better understand your health care needs. Please circle the answer that applies to you.

How do you rate your health?	Very unhealthy	Unhealthy	Average health	Healthy	Very healthy
Over the last year, how satisfied have you been with your health care?	Very dissatisfied	Dissatisfied	Neutral	Satisfied	Very satisfied
In the past year, how many times have you been treated in an Emergency Room?	5 or more		2-4	0 or 1	
In the past year, how many times have you been hospitalized?	3 or more		2	0 or 1	

We would like to know about your experience with past medical care. Thank you so much.

I had one person that I thought of as my personal doctor or nurse.	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
It was easy for me to get medical care when I needed it.	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
Most of the time, when I visited my doctor's office, it was well-organized, efficient, and did not waste my time.	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
The information given to me about health problems was very good.	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
I am confident that I can manage and control most of my health problems.	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree

Other comments or suggestions:

SWEDISH FAMILY MEDICINE – BALLARD

Teen Medical History (11-18 year olds)

Name:	Date of Birth:
Mother's Name:	Today's Date:
Father's Name:	If parents divorced/separated, who has custody?
Is your child either: <input type="checkbox"/> Native American or <input type="checkbox"/> Native Alaskan	

Past Medical History

Please place a checkmark next to any condition you have had:

Heart or Blood Vessels	Muscles, Joints and Bones
Heart murmur	Arthritis
Abnormal heart rhythm	Other:
Other:	Social or Mental Health
Lungs	Depression
Asthma	Anxiety
Other:	Attention deficit disorder
Digestion	Learning disorder
Inflammatory bowel disease	Sleep problems
Other:	Behavior problems
Kidneys or Bladder	Other:
Frequent bladder infections	Infectious Diseases
Other:	Hepatitis
Metabolism	HIV
Diabetes	Other:
Thyroid problems	Skin
Other:	Eczema
Nerves and Brain	Other:
Seizures	Other
Other:	

Did you visit the emergency room or need hospitalization in the last year?

Date	Reason

Surgical History

Type of Surgery	Year	Surgeon

For Young Women

Have you started your periods? <input type="checkbox"/> No <input type="checkbox"/> Yes: If Yes, when?	
Are your periods: <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Heavy <input type="checkbox"/> Accompanied by severe cramping	
Do you use birth control? <input type="checkbox"/> No <input type="checkbox"/> Yes: If Yes, what type?	
Have you ever had a PAP smear? <input type="checkbox"/> No <input type="checkbox"/> Yes: If Yes, when?	
Have you ever been pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes	
If Yes, list date(s):	Outcome(s):

Health Maintenance

Are your immunizations up-to-date? <input type="checkbox"/> No <input type="checkbox"/> Yes (Please attach immunization records.)
Last well-child exam:
Last dental visit:
Diet (please describe):
How many times/week do you exercise? <input type="checkbox"/> 0 <input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5-7
How many minutes do you exercise each time? <input type="checkbox"/> 10-15 <input type="checkbox"/> 15-30 <input type="checkbox"/> 30-45 <input type="checkbox"/> >45 min
Types of activities:
Do you see an alternative health-care provider (chiropractor, naturopath, acupuncturist)? <input type="checkbox"/> No <input type="checkbox"/> Yes

Allergies

Medication or Other Item	Reaction (e.g., rash, swelling, difficulty breathing)

Medications

Medication (including vitamins, herbs, supplements)	Dose	Frequency	Prescribed by

Family Medical History

Please place a check next to any conditions that an immediate family member has (parents, grandparents, siblings):

	Who
Asthma, allergies	
Cancer (what type?)	
Diabetes	
Heart attack or heart disease	
High blood pressure	
Mental health problems	
Inherited disorders	
Other conditions	

Social History

School:	Grade:
Any problems at school requiring special attention? <input type="checkbox"/> No <input type="checkbox"/> Yes: If Yes, what:	
Are your parents: <input type="checkbox"/> Married/partnered <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Who lives at home with you?	
Name	Relationship
	Age
TV (hours/day):	Computer/Video games (hours/day):

Please answer the following questions by placing a checkmark under either the "Yes" or "No" column:

	Yes	No
Do you have any concerns about your mental or physical development or mood?		
Do you have a smoke detector in the home?		
Do you wear a bike helmet when biking?		
Do you use a seatbelt?		
Are there guns in the home?		
Do you feel safe in your home and neighborhood?		
Is there any history of abuse in the home? (emotional, sexual, physical)?		
Does anyone smoke in the home?		
Are there any alcohol or street drug problems in the home?		
During the past 2 weeks, have you felt down, depressed or hopeless?		
During the past month, have you often felt so anxious that you couldn't stand it?		