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
1801 N.W. Market St., Suite 403
Seattle, WA 98107

www.swedish.org

SWEDISH FAMILY MEDICINE – BALLARD

Teen Medical History (11-18 year olds)

Name:	Date of Birth:
	Today's Date:
Mother's Name:	If parents divorced/separated, who has custody?
Father's Name:	
Is your child either: ☐ Native American or ☐ Native Alaskan	

Past Medical History

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

Heart or Blood Vessels	
	Heart murmur
	Abnormal heart rhythm
	Other:
Lungs	
	Asthma
	Other:
Digestion	
	Inflammatory bowel disease
	Other:
Kidneys or Bladder	
	Frequent bladder infections
	Other:
Metabolism	
	Diabetes
	Thyroid problems
	Other:
Nerves and Brain	
	Seizures
	Other:

Muscles, Joints and Bones	
	Arthritis
	Other:
Social or Mental Health	
	Depression
	Anxiety
	Attention deficit disorder
	Learning disorder
	Sleep problems
	Behavior problems
	Other:
Infectious Diseases	
	Hepatitis
	HIV
	Other:
Skin	
	Eczema
	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? ☐ No ☐ Yes: If Yes, when?
Are your periods: ☐ Regular ☐ Irregular ☐ Heavy ☐ Accompanied by severe cramping
Do you use birth control? ☐ No ☐ Yes: If Yes, what type?
Have you ever had a PAP smear? ☐ No ☐ Yes: If Yes, when?
Have you ever been pregnant? ☐ No ☐ Yes If Yes, list date(s): Outcome(s):

Health Maintenance

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