

ADOLESCENT BASIC HISTORY (DHHS 2816)

- 1.-6. NAME, NUMBER, ETC. In the blank space in the top left on the front, attach the computer generated label or emboss the information imprinted on the patient's identification card or manually record the patient's name (last name, first name, and middle initial), identification number, date of birth (MM-DD-YY), race, gender, and county of residence.
7. ENGLISH SPEAKING Check "Yes" or "No" as appropriate. If "No", record the language spoken.
8. INTERPRETER Check "Yes" or "No" as appropriate. If "Yes", record who is providing interpretation.
9. ALLERGIES List all of patient's allergies: food, drugs, insects, environment. Record in red ink if possible.
10. DATE Record the date the initial history is taken.
11. SOURCE OF INFORMATION Check "Patient" when information is provided by the patient. Check "Other" when a parent or someone else is the informant. Specify the name of the informant. Indicate when both contributed significantly and include the quality of the information provided, (ie. poor historian, good historian, not sure of details, etc).
12. RELATIONSHIP Specify the relationship of the informant to the patient.
13. FAMILY HISTORY Indicate by "X" presence of any of these problems in patient or close relative(s). Indicate by "O" the absence of any of these problems in this same group. Detail positive findings. Information recorded on previously completed history forms may be referenced here. Update at subsequent well care visits. At the time of the update if no new findings are found, enter date and sign. **Family history is to be updated annually with any positive findings noted.**
14. CHILDHOOD MEDICAL HISTORY Record broad, general review of the perinatal period from information provided. Record problems at delivery that may have caused the patient to have any health or developmental problems.
15. DENTAL CARE Check "Yes" or "No" as appropriate. If "Yes", indicate where patient receives dental care.
16. INFECTIOUS DISEASES Indicate by "X" if patient has had disease. Indicate by "O" if patient has not had disease. **Update annually, noting any positive findings.**

DHHS 2816 (cont)

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| 17. | CHRONIC OR SERIOUS ILLNESS; INJURY; HOSPITALIZATION/ SURGERY | Record diagnosis, condition, or operation, date of occurrence and outcome. Detail when possible, whom and where care was given. Update annually, noting any positive findings. |
| 18. | SIGNATURE/INITIALS | Record full legal signature or initials of health professional responsible for this information. |

ADOLESCENT BASIC RISK ASSESSMENT – 11 to 21 Years

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| 19. | ASTHMA TRIGGERS | Check "Yes" or "No" as appropriate. Update annually. |
| 20. | SUBSTANCE ABUSE | Record substance use/abuse information.
*Alcohol- Identify type or types used and average consumption.
*Drugs- Record drugs, Rx, OTC, or Illicit drugs.
*Tobacco-Record average number of packs of cigarettes, number of pipefuls, cigars or wads of chewing tobacco or dips of snuff. Update annually. |
| 21. | PSYCHO-SOCIAL PROBLEMS | Indicate "Yes" or "No" as appropriate. Update annually. |
| 22. | REPRODUCTION | Female- Record age at menarche. Record onset of last normal menstrual period. Record findings as noted.

Male- Record findings as noted.

Male and Female- Record findings as noted. Update section annually.

SIGNATURE OR INITIALS AND DATE- Record legal signature or initials of health professional obtaining information. |
| 23. | DIETARY SCREENING/ ACTIVITY SCREENING | Record findings as noted. Update annually. |
| | SIGNATURE OR INITIALS/DATE | Record legal signature of health professional obtaining information. |