

## Health Maintenance Exam Age 13-18

NAME: \_\_\_\_\_ Age: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Any new family health problems?  
Who lives in your home?

### NEW OR CONTINUING PROBLEMS:

(circle any that apply)

General: Fevers or chills. Weight change. Appetite change.  
Eyes: Vision concerns. Eye discharge or discomfort.  
**Eye care provider and last exam:**  
Ears: Change in hearing or ear pain. Nasal congestion or bleeding.  
Mouth: Mouth sores, sore throat, dental problems  
**Dental provider and last exam:**  
Heart: Chest pain or heart concerns  
Lungs: Cough or shortness of breath.  
Breasts: Pain, nipple discharge or masses  
Bowels: Abdominal pain, change in bowels, bleeding, heartburn  
Urinary: Urinary problems, menstrual problems  
Muscle/bone: Injuries, joint or muscle or back pain  
Brain, spine: Headaches, coordination problems  
Skin: Rashes or concerning lesions  
Metabolism: Unusual thirst or weight loss.  
Emotions: Depression or anxiety; school problems, fears  
Allergy: Allergy symptoms

MEDICATIONS (PRESCRIPTION AND NON-PRESCRIPTION):

MEDICATION ALLERGIES:

Sleeping - typical wake and sleep times

Any problems at home or at school?

Favorite activities?

How many hours of TV per day?      TV in your room?

How often do you use your seat belt?

How many meals do you eat per day?