



Middle-Older Adolescent Update Sheet

Name: _____ Date of Birth: _____

Current Medications: _____

Allergies: _____ Date: _____

Medical History

Recent Surgeries/Hospitalizations (Dates/Reasons): _____

Social History

Tobacco:

Do you ever smoke cigarettes/cigars, use snuff, or chew tobacco?

Yes No

Alcohol:

In the past, have you ever gotten drunk drinking beer, wine, or any other alcohol?

Yes No

Drugs:

Do you ever use marijuana, other drugs, or sniff inhalants?

Yes No

Do you ever use non-prescription drugs to get to sleep, stay awake, calm down, or get high?

Yes No

Developmental

Have you ever had sexual intercourse?

Yes No

Are you using methods to prevent pregnancy/sexually transmitted diseases?

Yes No

Have you ever been told by a doctor or a nurse that you had a sexually transmitted infection (STI) or disease (STD)?

Yes No

Have you ever been pregnant or gotten someone pregnant?

Yes No

Do you have any topics you would like to discuss with the doctor today?
