Stanford HEALTH CARE
STANFORD MEDICINE

NEW PATIENT QUESTIONNAIRE-ADOLESCENT

Ages 12-17

Name: _____

Legal Name if different: _____ Please place Label Here

Pronouns (optional): _____

Date Of Birth: _____

Reason For Visit Today

_____

_____

Preferred Pharmacy

_____ Address: _____

Current Medications- Including OVER THE COUNTER medications

Name	Dose & Direction	Reason For Medication

Allergies and Reactions

Allergen	Type Of Reaction

Who else lives in your household?

_____

_____

_____

_____

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Check all that applies to past and present medical conditions

☐ Alcohol/Drug Issue	☐ Anemia	☐ Anxiety
☐ Asthma	☐ Depression	☐ Heart Murmur
☐ Allergies	☐ Gender Dysphoria	☐ Hepatitis
☐ Thyroid Problem	☐ Pneumonia	☐ Urinary Infection
☐ Mononucleosis	☐ Broken Bone	☐ Knocked Unconscious
☐ Knee or Hip Problem	☐ Foot Problems	☐ Hearing Problems
☐ Vision Problem	☐ Curvature of the spine	

Health Maintenance

Do you feel like you eat a nutritious diet?

☐ Yes ☐ No

Do you eat breakfast?

☐ Rarely/Sometimes ☐ Daily/Almost Daily

Do you eat between meals?

☐ Rarely/Sometimes ☐ Daily/Almost Daily

How is your current weight?

☐ Underweight ☐ Normal ☐ Overweight

How many hours of sleep do you get each night?_____