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First Visit Form for Teens

We look forward to your first visit in our office! Please find a quiet moment to complete this form to bring to your appointment. We have carefully chosen these questions to address all aspects of your health. Your answers will help us to work with you in a way that best meets your health care needs. Feel free to skip any questions that you do not wish to answer. If there are questions that you prefer not to answer in writing but wish to discuss in-person, we may do so at your appointment.

Today's Date: _____

First Name _____ **Middle Initial** _____ **Last Name** _____

Date of Birth ___/___/___

Phone Number Home (____) _____ Cell or pager (____) _____
Work (____) _____

Where can we leave a confidential message? (circle one) Home Work Cell

Email Address _____

Mailing Address _____

Emergency Contact Name _____
Relationship _____
Phone Number Home (____) _____ Work (____) _____

Ethnicity: (circle one) Latino Asian/Pacific Islander Black White Native American
Other : _____

Who referred you to Dr. Miller or Dr. Swan? _____

Please describe the **major expectations** that you have of your family doctor:

Please list the names of **physicians and complementary medicine providers** who have treated you in the recent past:

Name	Telephone # (optional)	Profession/Specialty	Dates of treatment	
			From	To

Please list the names of **psychiatrists, psychologists, counselors and psychotherapists** who have treated you in the recent past:

Name	Telephone # (optional)	Profession/Specialty	Dates of treatment	
			From	To

What **medications and remedies** are you currently taking? This includes over-the-counter medications, homeopathic and herbal remedies, and nutritional supplements.

Name	Dose or quantity per day	When did you start it?

Do you have any **ALLERGIES** to medications? (circle one) YES NO

If yes, please describe _____

Please list any **hospitalizations or surgeries** you have had:

Reason for hospitalization or surgery	Date

What **exercise activities** do you do in a typical week?

Activity Type	Times per week	Minutes per time

Would you like to discuss your exercise regimen? (circle one) YES NO

What **foods** do you eat on a regular basis?

Breakfast foods	
Lunch foods	
Dinner foods	
Foods you crave	
Foods you dislike	
Snack foods	
Comfort foods	
Food allergies	

How many of your meals (including breakfast and lunch) each week are prepared in a restaurant or bought at a convenience store? _____

Where does your family usually shop for food? _____

What are your favorite junk foods? _____

Do you feel unhappy with the way your body looks? (circle one) YES NO

If yes, please explain: _____

Would you like to discuss your eating habits and diet? (circle one) YES NO

Do you or any of your friends consume any of the following? (check the boxes if 'yes')

	Me	Friends	How much per week	If quit, when?
Beer or wine				
Liquor				
Tobacco products				
Marijuana, cocaine, meth, Ecstasy, other drugs: (specify)				
Coffee, coke or other drinks with caffeine				

Do you feel that you have or had a problem with any of the substances listed above? (circle one) YES NO

If yes, please explain: _____

Overall do you feel that you get enough **sleep**? (circle one) YES NO

What time do you go to bed? _____ AM / PM

What time do you wake up? _____ AM / PM

What are the greatest sources of **stress** in your life? _____

What are the greatest sources of **comfort** in your life? _____

Who are the people, including members of your family, **who play a very important role in your life?**

Name	Relationship to you	Age	Where do they live?

Are you satisfied with your **friendships**? (circle one) YES NO

Do you have someone you can tell your deepest secrets to? (circle one) YES NO
If yes, who?: _____

Do you consider yourself heterosexual, homosexual, bisexual, transgender, other?

Have you, or a close family member, ever experienced **sexual abuse or assault**?
(circle one) YES NO If yes, please explain: _____

Do you use any form of **birth control** or **protection from sexually transmitted infections**?
(circle one) YES NO
If yes, please describe: _____

Have you ever had sexual intercourse? (circle one) YES NO
Have your friends ever had sexual intercourse? (circle one) YES NO

Do you belong to an **organized religion or spiritual group**? (circle one) YES NO
If yes, please describe: _____

Where are you in school? _____
What is your favorite subject? _____

Do you consider yourself to be a good student? (circle one) YES NO
If no, please explain: _____

Do you have any **difficulties with learning**? (circle one) YES NO

If yes, please describe:

What is your current **annual household income**? (circle one)

\$20,000 \$20,000-\$40,000 \$40,000-\$60,000 \$60,000-\$80,000

\$80,000-\$100,000 \$100,000-\$200,000 >\$200,000

Do you have any **concerns** about your current **FINANCIAL** situation? (circle one) YES NO

If yes, please describe:

Do you have any **concerns** about your current **LIVING** situation? (circle one) YES NO

If yes, please describe:

Women's Health:

Age of first menstrual period _____ Date of last menstrual period _____

Date of last: PAP _____ Pelvic exam _____

Mammogram _____ Breast exam _____

Have you ever had an abnormal PAP? (circle one) YES NO If yes, when _____

Number of pregnancies _____ Live births _____ Miscarriages _____

Is there **any other information** about you that you feel is important?

Thank You,

Daphne Miller, MD

Avril Swan, MD

Alex Zaphiris, MD

Medical History Please check the health problems that apply to each family member	S e l f	G r a n d p a r e n t	F a t h e r	M o t h e r	S i b l i n g	C h i l d	Please check all the symptoms that apply to you.	√
							Loss of Memory	
							General Weakness or Loss of Energy	
							Dizzy Spells, Fainting Spells or Blackouts	
							Frequent Headaches	
							Vision Disturbances	
Hearing Loss, Ringing in Ears								
Alcoholism							Ear pain or drainage	
Allergies/Hayfever							Nosebleeds	
Anemia							Sinus pains, Nasal Stuffiness	
Arthritis/Rheumatism							Frequent Sore Throat, Tonsillitis	
Asthma							Hoarseness	
Birth Defects							Swollen Glands	
Bleeding Disorders							Shortness of Breath	
Cancer or Tumor							Frequent Coughs, Wheezing	
Colitis or Crohn's							Palpitations, Chest Pains, Rapid Heartbeat	
Congenital Heart Disease							Anxious Feeling in Chest or Stomach	
Depression							Poor Appetite	
Diabetes							Indigestion	
Emphysema, COPD							Abdominal Pain, Discomfort, Bloating	
Epilepsy, Seizures							Constipation, Use of Laxatives	
Frequent Infections							Diarrhea, Bloody Stools	
Genetic Disease							Rectal Pain, Itching, Irritation	
Glaucoma, Cataracts							Hemorrhoids, Anal Fissures	
Gonorrhea/Chlamydia							Difficulty Urinating	
Gout							Urinary Incontinence	
Herpes							Burning with urination	
Heart Disease/Heart Attacks							Frequent urination	
High Blood Pressure							Breast pain or discharge	
HIV, AIDS							Breast lumps	
Infertility							Pain with intercourse	
Kidney Disease							Men: Penis or testicle problem	
Liver Disease, Hepatitis							Men: Difficulty maintaining an erection	
Mental Illness							Women: Irregular or painful periods	
Migraine Headaches							Women: Premenstrual tension/mood swings	
Nervous Breakdown							Women: Vaginal Itch or odor	
Obesity							Women: Vaginal dryness	
Osteoporosis							Swollen or painful legs	
Peptic Ulcer Disease							Back Pain, Sciatica	
PID							Joint Pain, Joint Swelling	
Prostate Problems							Skin discoloration, rashes, sores, moles	
Psoriasis, Eczema							Severe perspiration, nightsweats	
Rheumatic Fever							Nightmares, Recurrent Dreams	
Stroke							Fears or Phobias	
Suicide (or attempted)							Anxiety or Nervousness	
Thyroid Disease							Angry, Irritable, Impatient, Critical	
Tuberculosis							Sadness, Grief, Depression	
other							other	