



HEALTH HISTORY FORM

Child Adolescent Health Center

GENERAL INFORMATION:			
Patient Name:		DOB:	
Primary Care Physician:	PH#:	Dental Home:	PH#:
<i>Date last seen:</i>	<i>Date of last well child/physical:</i>	<i>Date last seen:</i>	<i>Date of last exam:</i>

STUDENT MEDICAL HISTORY: HAS THE STUDENT HAD ANY OF THE FOLLOWING? IF YES, CHECK ALL THAT APPLY.

<input type="checkbox"/> ADD/ADHD or Learning Disability (IEP?)	<input type="checkbox"/> Asthma or Shortness of Breath	<input type="checkbox"/> Cancer
<input type="checkbox"/> Anemia or Bleeding Disorder	<input type="checkbox"/> Autism/Autism Spectrum Disorder	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Eye Problems (glaucoma/impaired vision)	<input type="checkbox"/> Bladder or Kidney Problems or Infections	<input type="checkbox"/> Digestive Problems
<input type="checkbox"/> Headaches or Migraines	<input type="checkbox"/> Heart Problems (high blood pressure/congenital heart defect/rheumatic fever/irregular heartbeat)	<input type="checkbox"/> Hearing Problems
<input type="checkbox"/> Liver Problems (hepatitis/jaundice)	<input type="checkbox"/> Neurological Problems (cerebral palsy/seizures/brain injury)	<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Mood Difficulties (depression/anxiety/suicidal thoughts/self-harm/eating disorder)	<input type="checkbox"/> Respiratory Problems (sleep apnea/snoring/cystic fibrosis)	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Premature Birth or Birth defects	<input type="checkbox"/> Sickle Cell Disease or Trait	<input type="checkbox"/> Skin Problems (acne, rash)
<input type="checkbox"/> Sports Injuries/Broken Bones/Injury to Face or Teeth	<input type="checkbox"/> Sexually Transmitted Infections (HIV/AIDS/gonorrhea/chlamydia/ trichomonas)	<input type="checkbox"/> Infectious Disease (recurrent sinusitis/measles/mumps/mononucleosis/pneumonia/meningitis/scarlet fever/chicken pox/TB/strep)

Surgeries & Dates:	List of all current medications & vitamins?	Allergies/Reactions:

STUDENT SOCIAL HISTORY

Has the student ever had drug/alcohol abuse? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes: <input type="checkbox"/> current problem <input type="checkbox"/> receiving treatment <input type="checkbox"/> recovering	Does the student feel safe at home? <input type="checkbox"/> No <input type="checkbox"/> Yes
Does the student use any marijuana products? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes: <input type="checkbox"/> Smoke <input type="checkbox"/> Vape <input type="checkbox"/> Edibles	Does the student use tobacco products? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes: _____ day X _____ yrs <input type="checkbox"/> cigarettes <input type="checkbox"/> vape <input type="checkbox"/> chew
What does the student drink throughout the day: <input type="checkbox"/> Pop <input type="checkbox"/> Diet Pop <input type="checkbox"/> Coffee/Tea <input type="checkbox"/> Juice <input type="checkbox"/> Water <input type="checkbox"/> Energy Drinks <input type="checkbox"/> Alcohol	

FAMILY MEDICAL HISTORY: ANY MEMBER OF THE STUDENT'S FAMILY (MOTHER, FATHER, SIBLINGS, AUNT, UNCLES, GRANDPARENTS) EVER HAD ANY OF THE FOLLOWING? IF YES, CHECK ALL THAT APPLY AND LIST WHO (MOTHER, FATHER, ETC.)

<input type="checkbox"/> Birth Defect Relationship:	<input type="checkbox"/> Diabetes Relationship:	<input type="checkbox"/> Immune Suppression/HIV/AIDS Relationship:	<input type="checkbox"/> Liver Disease/Hepatitis Relationship:	<input type="checkbox"/> Seizures Relationship:
<input type="checkbox"/> Thyroid Disease Relationship:	<input type="checkbox"/> Blood/Bleeding Disorders Relationship:	<input type="checkbox"/> Heart Disease (premature death/high blood pressure) Relationship:	<input type="checkbox"/> Kidney/Urine Disease Relationship:	<input type="checkbox"/> Lung Disease (COPD/asthma/other) Relationship:
<input type="checkbox"/> Skin Disorder Relationship:	<input type="checkbox"/> Tuberculosis Relationship:	<input type="checkbox"/> Cancer Relationship:	<input type="checkbox"/> High Cholesterol Relationship:	<input type="checkbox"/> Learning Disability Relationship:
<input type="checkbox"/> Mood Problems Relationship:	<input type="checkbox"/> Stomach Problems Relationship:	<input type="checkbox"/> Other Relationship:		

Signature of Parent/Guardian/Patient age 18 and older

Print Name

Date

Revised: 05/25/2021