NORTHWEST MICHIGAN HEALTH SERVICES INC

# Health History

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

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

| | | |
|---|---|---|
| ☐ ADD/ADHD or Learning Disability (IEP?) | ☐ Asthma or Shortness of Breath | ☐ Cancer |
| ☐ Anemia or Bleeding Disorder | ☐ Autism/Autism Spectrum Disorder | ☐ Diabetes |
| ☐ Eye Problems (glaucoma/impaired vision) | ☐ Bladder or Kidney Problems or Infections | ☐ Digestive Problems |
| ☐ Headaches or Migraines | ☐ Heart Problems (high blood pressure/congenital heart defect/rheumatic fever/irregular heartbeat) | ☐ Hearing Problems |
| ☐ Liver Problems (hepatitis/jaundice) | ☐ Neurological Problems (cerebral palsy/seizures/brain injury) | ☐ Scoliosis |
| ☐ Mood Difficulties (depression/anxiety/suicidal thoughts/self-harm/eating disorder) | ☐Respiratory Problems (sleep apnea/snoring/ cystic fibrosis) | ☐ Thyroid Problems |
| ☐ Premature Birth or Birth defects | ☐ Sickle Cell Disease or Trait | ☐ Skin Problems (acne, rash) |
| ☐ Sports Injuries/Broken Bones/Injury to Face or Teeth | ☐ Sexually Transmitted Infections (HIV/AIDS/gonorrhea/chlamydia/ trichomonas) | ☐ 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? ☐ No ☐ Yes<br>**If yes:** ☐ current problem ☐ receiving treatment ☐ recovering | Does the student feel safe at home? ☐ No ☐ Yes |
| Does the student use any marijuana products? ☐ No ☐ Yes<br>**If yes:** ☐ Smoke ☐ Vape ☐ Edibles | Does the student use tobacco products? ☐ No ☐ Yes<br>**If yes:** _____day X _____ yrs. ☐ cigarettes ☐ vape ☐ chew |

What does the student drink throughout the day: ☐ Pop ☐ Diet Pop ☐ Coffee/Tea ☐ Juice ☐ Water ☐ Energy Drinks ☐ 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.)**

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

_____ _____ _____

Signature of patent/guardian/Patient aged 18 and older | Print Name | Date