SBHC Initial Health History

Name: _____ Birthdate: _____ Today's Date: _____

ALLERGIES to Medications: _____

CURRENT MEDICATIONS (List ALL medications currently taking, including over-the-counter meds, herbs & vitamins)

1.	3.	5.
2.	4.	6.

HEALTH MAINTENANCE Have you had a physical exam in the past 12 months? Yes No

Are immunizations /vaccines up to date? Yes No Receives annual influenza (flu) vaccine or flumist? Yes No

PAST MEDICAL HISTORY: Please indicate if patient has had any of the following medical problems:

___ High Blood Pressure ___ Asthma/Lung Disease ___ Ulcers (stomach)

___ Diabetes ___ ADD/ADHD ___ Anemia

___ Depression/Anxiety ___Epilepsy/Seizures ___ Eczema/Hives/Rashes

___Heart Problems ___ Reflux/Gastritis ___ HIV/AIDS

Other: _____

SURGICAL HISTORY AND HOSPITILIZATIONS: List ALL prior hospitalizations and surgeries: _____

_____

FAMILY HISTORY: Indicate family members with any of the following conditions (parent, grandparent, sibling, aunt/uncle)

High Blood Pressure _____ High Cholesterol _____

Diabetes _____ Cancer _____

Heart Disease _____ Bleeding or Clotting Disorders _____

Stroke _____ Alcoholism _____

Mental Illness _____ Other _____

SOCIAL HISTORY: (circle any that apply)

HOUSING: Lives with Mother Father Both Parents Other _____

SCHOOL: Any problems/ concerns at school? No Yes If yes, describe _____

_____

TOBACCO USE: Does Patient smoke cigarettes? Never Former Current Smoker Exposure to Second Hand Smoke
Other tobacco use: Pipe Cigar Snuff Chew

ALCOHOL USE: Do you drink alcohol? Never Former Some Days Everyday # Drinks/Day _____

DRUG USE: Do you use recreational drugs? Yes No Have you ever used needles to inject drugs? Yes No

DIETARY INTAKE: Consumes regular diet including fruits, vegetables, dairy and protein? Yes No

REPRODUCTIVE: Are you sexually active? N/A No Yes Not Currently

FEMALE HEALTH HISTORY: Have you started your menstrual period Yes No Date of last menstrual period: _____
Age at start of menstrual periods _____ Are periods regular? Yes No

School Based Health Centers La Grande, 708 K Ave, 541-663-3330 Union, 540 Main St, 541-562-9418

SBHC Health History

Name: _____ Birthdate: _____ Today's Date: _____

Reason for today's visit: _____

In the past two weeks, how often have you been bothered by any of the following problems?

	Not at all	Several Days	More than half the days	Nearly every day
Little interest or pleasure in doing things:	0	1	2	3
Feeling down, depressed or hopeless:	0	1	2	3

REVIEW OF SYSTEMS: Please check any current problems you have on the list below

Constitutional

____ Fevers/chills/sweats

____ Unexplained weight loss/gain

____ Fatigue/weakness

____ Other: _____

Eyes

____ Change in vision

____ Glasses/contacts use

____ Other: _____

HENT

____ Headaches

____ Dental Problems

____ Decreased Hearing

____ Hayfever/seasonal allergies

____ Other: _____

Breasts

____ Lumps

____ Nipple discharge

____ Other: _____

Cardiovascular

____ Chest pain/discomfort

____ Unusual shortness of breath w/ exertion

____ Irregular heart beats

____ Other: _____

Respiratory

____ Cough/wheeze

____ Difficulty breathing/short of breath

____ Other: _____

Gastrointestinal

____ Abdominal pain

____ Blood in bowel movement

____ Nausea/vomiting/diarrhea

____ Constipation

____ Other: _____

Genitourinary

____ Pain with urination

____ Urinary urgency/ incr. frequency

____ Blood in urine

____Unusual vaginal bleeding

____ Pain or bleeding with intercourse

____ Genital sores

____ Other: _____

Skin

____ Rash or mole change

____ Acne

____ Hair growth change

____ Hair loss

____ Other: _____

Musculoskeletal

____ Muscle/joint pain

____ Other: _____

Neurological

____ Seizures

____ Numbness/tingling

____ Other: _____

Endocrine

____ Cold/heat intolerance

____ Hot flashes

____ Loss of hair

____ Increased urine production

____ Increased thirst

____ Other: _____

Psychiatric

____ Anxiety

____ Problems with sleep

____ Depression

____ Other: _____

_____

_____

_____

_____

_____

_____

_____

_____

Client Signature: _____ Date: _____ Parent ___ Self___

Reviewed by: _____ Date: _____