MINNEAPOLIS SCHOOL BASED CLINICS program

Personal Health History

All information shared on this form is confidential to the School Based Clinics

A program of the Minneapolis Department of Health & Family Support

Student Name (Last, First, MI)	Student ID #	Date

On a scale of 1 to 5, rate your health: Bad 1 2 3 4 5 Good

Do any of the following apply to you? *Check all that apply*

Allergies

- ❑ Medicine ❑ Pollen ❑ Food ❑ Pets

List:_____

- ❑ Asthma
- ❑ Cough a lot
- ❑ Shortness of breath *(when you play sports or exercise)*
- ❑ Chest pain and/or heart murmur
- ❑ Frequent headaches or migraines
- ❑ Skin problems
- ❑ Wear contacts/glasses
- ❑ Hearing problems

Medications

- ❑ Using Prescriptions ❑ Using over-the-counter

List:_____

- ❑ Use vitamins
- ❑ Herbal supplements ❑ Steroids or creatine use
- ❑ Unusual eating habits ❑ Use of diet pills
- ❑ Loss of appetite
- ❑ Vomit frequently
- ❑ Trouble sleeping ❑ Nightmares
- ❑ Being tired during the day
- ❑ Diarrhea ❑ Constipation ❑ Use of laxatives
- ❑ Upset stomach
- ❑ Wear braces, dental bridges

- ❑ Leg, joint or back pains
- ❑ Broken bones
- ❑ Surgery List: _____
- ❑ Head injury/fainting spells/unconsciousness
- ❑ Ever passed-out from exercise
- ❑ Feeling down or depressed
- ❑ Thoughts about suicide
- ❑ Troubled about future plans
- ❑ Anger or problems with temper
- ❑ Separation or divorce of parents
- ❑ Lack of self-confidence
- ❑ Feelings of loneliness
- ❑ Trouble with school or teachers
- ❑ Worried about height or weight
- ❑ Feelings of anxiety or nervousness
- ❑ Worried about getting a job
- ❑ Worried about a place to live
- ❑ Wetting the bed
- ❑ Financial problems

Have you ever had:

Chicken Pox	❑ Yes	❑ No
Positive tuberculosis (TB) test	❑ Yes	❑ No

Do you regularly wear:

Seat belts	❑ Yes	❑ No
Bike or motorcycle helmets	❑ Yes	❑ No

When was your last dental visit?_____

Please answer the following questions:

1. Are both of your parents alive? ❑ Yes ❑ No ❑ Don't Know
2. Who do you live with?_____
3. Has anyone in your family died before age 50? ❑ Yes ❑ No ❑ Don't Know
4. Has anyone in your family been hospitalized? ❑ Yes ❑ No ❑ Don't Know
5. Have you or anyone in your family had a history of ❑ Don't know family history

- ❑ Anemia
- ❑ Asthma
- ❑ Bleeding problems
- ❑ Cancer
- ❑ Thyroid disease
- ❑ Diabetes
- ❑ Gallbladder disease
- ❑ High blood pressure/heart disease/strokes/blood clots
- ❑ High cholesterol
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Other, explain: _____
- ❑ Migraine headaches
- ❑ Problems with alcohol/drug use
- ❑ Mental health problems
- ❑ Seizures or epilepsy
- ❑ Sickle cell disease/trait

Staff Comments:

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6. Do you chew tobacco? ❑ No ❑ Yes, how many tins per week?_____
7. Do you smoke cigarettes? ❑ No ❑ Yes, how many cigarettes per week?_____
8. Do you drink any type of alcohol? ❑ No ❑ Yes, what kinds?_____
   How often do you drink? ❑ daily ❑ weekends ❑ once a month ❑ special occasions only
   When was the last time you drank?_____Have you ever blacked-out after drinking? ❑ No ❑ Yes
   Have you ever been drunk? ❑ No ❑ Yes, when was the last time?_____
   ❑ Problems with alcohol/drug use
9. Have you used any of the following street drugs? ❑ heroin ❑ cocaine ❑ cocaine ❑ crack ❑ marijuana ❑ meth/crank
   ❑ "club drugs" or ecstasy ❑ speed ❑ other, specify: _____
10. .How often do you use street drugs?_____When was the last time you were high?_____
11. Have you been through drug and/or alcohol treatment or are you currently in treatment? ❑ No ❑ Yes
12. Do you have sex when you are using pot, alcohol or other street drugs? ❑ No ❑ Yes
13. Have you driven a car under the influence of alcohol or street drugs? ❑ No ❑ Yes
14. Have you ridden with someone who was under the influence? ❑ No ❑ Yes
15. Have you ***ever*** been sexually active? ❑ No, *skip to question #27* ❑ Yes, *continue to question #16*
16. In what ways are you sexually active? ❑ kissing ❑ touching/rubbing ❑ vaginal sexual intercourse ❑ anal sex ❑ oral sex
17. Are your sexual partner/s ❑ male ❑ female ❑ both
18. Who is responsible for birth control in your sexual relationship? ❑ yourself ❑ your partner ❑ both ❑ neither
19. What method(s) of pregnancy prevention and/or disease prevention have you used in the past?
    ❑ Birth Control Pill ❑ Condom ❑ Depo ❑ NuvaRing ❑ Patch ❑ IUD ❑ Withdrawl
    ❑ Vagnial Contraceptive Film ❑ None
20. Which birth control method/s do you use now? ❑ Birth Control Pill ❑ Condom ❑ Depo ❑ NuvaRing ❑ Patch ❑ IUD
    ❑ Withdrawl ❑ Vagnial Contraceptive Film ❑ None
21. If you use condoms, have you had any problems using them? ❑ No ❑ Yes
22. Number of sexual partners ever:_____Number of sexual partners in the last 3 months?_____
23. Do you worry about sex and/or pregnancy? ❑ No ❑ Yes
24. Have you had any other the following conditions? *(please check all that apply)*
    ❑ Chlamydia ❑ Genital Warts ❑ Gonorrhea ❑ Herpes ❑ Syphilis ❑ Pelvic Inflammatory Disease ❑ Trich
25. Do you think you have been exposed to a sexually transmitted infection (STI)? ❑ No ❑ Yes ❑ Not sure
26. Are you worried about your relationship with your partner? ❑ No ❑ Yes
27. Have you talked with family member(s) about sexuality and birth control matters? ❑ No ❑ Yes
28. Have you ever had a urinary tract infection (bladder infection)? ❑ No ❑ Yes
29. Do you currently have: ❑ itching of the penis or vagina ❑ discharge or drainage ❑ odor
30. Have you ever been abused or hurt by someone? ❑ No ❑ Yes, Describe_____
31. Have you ever sexually forced yourself on another person? ❑ No ❑ Yes
32. Have you ever been forced to have sex against your will? ❑ No ❑ Yes

Males Only

33. When was your last testicular (balls) examination?_____Self examination?_____
34. Do you have children? ❑ No ❑ Yes, how many?_____
35. If you have children, how are you involved?_____

Females Only

36. Menstrual cycle started at what age?_____Monthly? ❑ No ❑ Yes, how many days do you bleed?_____
37. Do you have spotting or bleeding in between periods? ❑ No ❑ Yes Date of your last period:_____
38. Do you have problems/pain with your menstrual periods? ❑ No ❑ Yes
    Have you missed school for cramps? ❑ No ❑ Yes
39. What medications have you used for cramps?_____Does it help? ❑ No ❑ Yes
40. Have you ever been pregnant? ❑ No ❑ Yes, do you have children? ❑ No ❑ Yes, how many?_____
41. Have you ever had a pelvic examination? ❑ No ❑ Yes
42. Have you had a Pap smear test? ❑ No ❑ Yes, what was the Pap result: ❑ Normal ❑ Abnormal Date:_____

Reviewed By:	Date: