Mankato Clinic

Health History 11 - 14 years

Interpreter Present: ___ Yes ___ No
Name: ______________________________
Language: ______________________________

Brought into Clinic by: ______________________
List any questions or concerns you have about your child:
____
____
____

PAST HEALTH HISTORY

Parent, please help your child complete this form.

Have you ever had any of the following? If yes, please list what they had and when it occurred:

	Yes	No
1. Allergic reaction to:		
▪ Medications ______________	☐	☐
▪ Foods ______________	☐	☐
▪ Insect bites______________	☐	☐
▪ Immunizations (shots)__________	☐	☐
2. Hospitalizations?______________	☐	☐
3. Surgery?______________	☐	☐
4. Head injuries? ______________	☐	☐
5. Serious injuries______________ or accidents?	☐	☐
6. Broken bones or stitches? __________	☐	☐
7. Sports injuries?______________	☐	☐
8. Fainting episodes? ______________	☐	☐

Have you required any special tests? ☐Yes ☐No
If yes, describe: ______________________________
____
____
____

Please list any information about you that you feel we should know: ______________________
____
____
____
____
____

MC536j (07/14)

Please check (√) if you have ever had any of the following:

☐ ADD / ADHD
☐ Anemia (low-iron in blood)
☐ Anxiety
☐ Asthma
☐ Autism / PPD
☐ Bladder/Kidney infection
☐ Chickenpox
☐ Depression
☐ Diabetes
☐ Ear infections
☐ Frequent respiratory infections
☐ Hayfever / Allergies
☐ Meningitis
☐ Pneumonia
☐ Seizures
☐ Sinus infections
☐ Strep infections/ Scarlet Fever
☐ None

CURRENT HEALTH HISTORY

- Please list any medications taken on a regular basis, including over-the-counter and herbal preparations:
  ____
  ____
- Have you had all your immunizations (shots)? ☐Yes ☐No ☐ I don't know

A. Eating / Nutrition

1. How do you eat? ☐ Excellent ☐ Good ☐Fair ☐Poor
2. List any concerns you have about your eating or nutrition: ______________________
   ____
   ____
3. Do you take vitamins? ☐Yes ☐No

4. Are you concerned about your weight? ☐Yes ☐No
   - What do you think your ideal weight is?_____
   - In the last year what was your:
     - lowest weight? _________
     - highest weight? _________
   - Have you ever made yourself throw up or taken laxatives to control your weight? ☐Yes ☐No

5. Rate how you eat these foods:

	Good	Fair	Poor
▪ Dairy/Milk	☐	☐	☐
▪ Fruit	☐	☐	☐
▪ Vegetables	☐	☐	☐
▪ Meats	☐	☐	☐
▪ Bread/Cereal/Pasta	☐	☐	☐

6. How many times per day do you eat sweets, chips, junk foods, etc? ______________________
7. How many cans of pop do you drink in:
   - a day? _________________
   - a week? _________________

B. Elimination

1. Do you have any problems with:
   - Constipation? ☐Yes ☐No
   - Diarrhea? ☐Yes ☐No
   - Blood in your stool? ☐Yes ☐No

2. Any concern with urination (peeing)? ☐Yes ☐No
   - Pain when urinating? ☐Yes ☐No
   - Urinating very often in small amounts? ☐Yes ☐No
   - Bed-wetting? ☐Yes ☐No
   - Blood in urine? ☐Yes ☐No

C. Sleep

1. Any concerns regarding sleeping? ☐Yes ☐No
   List ______________________________________
   ____
2. What time do you:
   - Go to sleep at night? ___________________
   - Get up in the morning? _________________
3. Any difficulty falling asleep at night? ☐Yes ☐No
4. Do you wake up frequently at night? ☐Yes ☐No
5. Are you always tired, even after a good night's sleep? ☐Yes ☐No

D. Dental

1. Do you brush your teeth? ☐Yes ☐No
   - What time of the day? _____________________
2. Do you floss your teeth? ☐Yes ☐No
3. Date of last dental visit: _______________
4. List any dental concerns:_________________________
   ____
5. Do you have bleeding or sore gums? ☐Yes ☐No
6. Any canker sores in your mouth? ☐Yes ☐No

E. Safety

1. Do you wear a seat belt? ☐Yes ☐No
2. Do you wear a bicycle helmet? ☐Yes ☐No
   - On a scale from 0 – 5, how often?
     (Never) 0 1 2 3 4 5 (Always)
3. Do you wear wrist guards when you rollerblade? ☐Yes ☐No ☐I don't rollerblade
   - On a scale from 0 – 5, how often?
     (Never) 0 1 2 3 4 5 (Always)

F. School / Social

1. Do you like school? ☐Yes ☐No
2. Do you have friends your own age? ☐Yes ☐No
3. What grades do you get in school? _______________
4. Have you required any special classes or help in school? ☐Yes ☐No
5. Favorite subject ________________________________
   Least Favorite subject ___________________________
6. Are you having any problems in school? ☐Yes ☐No
   - If yes, what are they? _______________________
     ____
     ____
     ____
7. What sports activities are you involved in? _________
   ____
   ____
   ____

G. Activity / Hobbies

1. What do you do for exercise? ___________________
   ____
   How often?__________________________________
3. How much TV do you watch per day?
   ☐ 0-1 hr ☐ 1-2 hrs ☐ 2-5 hrs ☐ 5 or more hrs
4. Do you have any hobbies? ☐Yes ☐No
   If yes, what are they? _________________________
   ____
   ____

H. Family

1. Who lives at your house? ___________________
____
2. Are you having any problems at home? ☐Yes ☐No
   - If yes, please explain: ___________________
____
____
3. How do you get along with your:
   - Parents? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
   - Brothers/Sisters? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
4. Do you have any pets? ☐Yes ☐No
5. Does anyone in your family smoke? ☐Yes ☐No
   - If yes, who? ___________________
6. Are there guns in your house? ☐Yes ☐No
7. Does anyone in your family have a problem with alcohol? ☐Yes ☐No
   - If yes, who? ___________________
8. Does anyone in your family have a problem with drugs? ☐Yes ☐No
   - If yes, who? ___________________
9. Do you have any concerns about safety at your house? ☐Yes ☐No
   - If yes, please explain: ___________________
____
____
10. Is there violence in any of your family relationships? ☐Yes ☐No
    - If yes, please explain: ___________________
____
____
____

I. Tuberculosis (T.B.)

1. Has your child ever been treated for tuberculosis? ☐Yes ☐No
2. Has your child ever been around anyone with tuberculosis? ☐Yes ☐No

J. Reproduction

If you are a female:

1. Have you started your menstrual period? ☐Yes ☐No
   - If yes, how old were you when you started? __________
   - How often does it occur? ___________________
   - Do you get menstrual cramps? ☐Yes ☐No
   - What was the date of your last period? ______________
2. Have you had any unusual vaginal discharge? ☐Yes ☐No
3. Do you have any tenderness, redness or discharge from your breasts? ☐Yes ☐No

If you are a male:

1. Have you noticed any sores on your penis? ☐Yes ☐No
2. Have you noticed any discharge from your penis? ☐Yes ☐No

K. Chemical

1. How often do you use tobacco products?___________
   What kind? ___________________
   How much/day?___________________
2. How often do you drink alcohol? ___________________
   How much do you drink/day? ___________________
   ____
3. How often do you use drugs? ___________________
   How much do you use/day? ___________________
   ____
4. Check (√) what you have tried:

☐ Acid/LSD ☐ Ice ☐ Pot
☐ Crack/Coke ☐ IV Drugs ☐ Sniffing
☐ Diet pills ☐ Meth ☐ Speed/crack
☐ Heroin ☐ PCP/Dust ☐ Steroids
☐ Other ___________________

L. Family History

☐ I am adopted, family history is unknown.
☐ One or more of my parents is adopted, family history is unknown.

1. Are your parents in good health? ☐Yes ☐No
2. Check (√) any diseases that your **parents, grandparents, brothers, sisters, aunts or uncles** have had and indicate which family member in space provided:

☐ Alcohol or drug problems ___________________
☐ Allergies/Hayfever ___________________
☐ Asthma ___________________
☐ Birth defects ___________________
☐ Bleeding disorders ___________________
☐ Cancer ___________________
☐ Diabetes ___________________
☐ Ear infections ___________________
☐ Eczema/Psoriasis___________________
☐ Epilepsy/Seizures ___________________
☐ Hearing problems/Deafness ___________________
☐ Heart murmur___________________
☐ Heart problems/Heart attacks ___________________
☐ High blood pressure ___________________
☐ High cholesterol___________________

Family History (continued)

☐ Kidney problems/Bladder infections_____________
☐ Learning problems ___________________________
- ADD / ADHD ___________________________
- Reading problems ______________________

☐ Mental illness/Depression _____________________
☐ Migraine Headaches_________________________
☐ Obesity (overweight)_________________________
☐ Scoliosis (curvature of the spine) _______________
☐ Sinus problems______________________________
☐ Stroke ____________________________________
☐ Sudden deaths during exercise________________
☐ Thyroid problems ___________________________
☐ Tuberculosis_______________________________
☐ Ulcers_____________________________________
☐ Vision problems:
- Crossed eyes _________________________
- Glaucoma ___________________________
- Cataracts ____________________________
- Lazy Eye______________________________

M. Review of Systems

Check (√) if you have any of the following:

☐ Blurry vision / Difficulty seeing	☐ Frequent sore throat
☐ Bruises easily	☐ Headaches
☐ Clumsy/awkward	☐ Heart murmur
☐ Crossed eyes	☐ Hoarse sounding voice
☐ Difficulty Breathing	☐ Mattery eyes
☐ Difficulty Hearing	☐ Muscle/joint pain
☐ Difficulty swallowing	☐ Poor activity level/easily tired
☐ Dizziness	☐ Rashes
☐ Dry skin	☐ Red eyes
☐ Falling down more than other kids your age	☐ Stomach cramps
☐ Frequent cough	☐ Vomiting
☐ Frequent ear infections	☐ Walking funny - toes in or out
☐ Frequent runny / stuffy nose	☐ Other __________ __________
☐ None	

N. Circle the answer that best describes how you feel:

I am happy:

always most of the time sometimes

I like myself:

always most of the time sometimes

O. I have questions about: _______________________
____
____
____
____
____

P. Active Community Services

Please check (√) if you participate in any of the following:

☐ Public Health
☐ MFIP
☐ Spiritual
☐ Other ____________________________________

Reviewed by ________________________________

(Medical Provider's signature)