Mankato Clinic

Health History 15 - 20 years

Interpreter Present: ___ Yes ___ No
Name: ______________________________________
Language: ____________________________________

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

To help us know you better and what your needs are, we ask that you please complete this history form to the best of your knowledge.
The information you provide on this form is confidential. We cannot discuss any of this information with anyone other than yourself, without your permission. However, there are three exceptions to this – if we feel that you are being hurt by anyone, you are going to hurt yourself, or you are going to hurt anyone else. In these three cases, we must report this information to certain people. We will talk with you before we share this information with anyone. Thank you.

PAST HEALTH HISTORY

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:		
▪ Medication ____________	☐	☐
▪ Foods ____________	☐	☐
▪ Insect bites ____________	☐	☐
▪ Immunizations (shots) ____________	☐	☐
▪ Trees, molds, dust, etc ____________	☐	☐
▪ Animals ____________	☐	☐
▪ Tape, Latex, or other ____________	☐	☐
2. Hospitalizations? ____________	☐	☐
3. Surgery? ____________	☐	☐
4. Head injuries? ____________	☐	☐
5. Serious injuries or accidents? ____________	☐	☐
6. Broken bones or stitches? ____________	☐	☐
7. Sports injuries? ____________	☐	☐
8. Fainting episodes? ____________	☐	☐
9. Loss of consciousness? ____________	☐	☐
10. Concussion? ____________	☐	☐

MC536k (07/14)

Have you required any special tests? ☐Yes ☐No

- If yes, describe: ______________________________
  ____
  ____
  ____
  ____

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

☐ ADD/ADHD
☐ Alcoholism or chemical dependency
☐ Anemia (low-iron in blood)
☐ Asthma
☐ Bladder/Kidney infection
☐ Blood clots
☐ Blood transfusion
☐ Chickenpox
☐ Depression
☐ Diabetes
☐ Ear infections
☐ Eating disorder – bulimia or anorexia
☐ Frequent respiratory infections
☐ Hayfever / Allergies
☐ None
☐ Liver problems
☐ Meningitis
☐ Migraine headaches
☐ Mononucleosis
☐ Pelvic Inflammatory Disease (P.I.D.)
☐ Pneumonia
☐ Seizures
☐ Sexally Transmitted Infections:
  ☐ Chlamydia
  ☐ Genital herpes
  ☐ Genital warts
  ☐ Gonorrhea
☐ Syphilis
☐ Sinus Infections
☐ Strep infections/ Scarlet Fever

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

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? ☐Yes ☐No ☐ I don't know

- On a scale of 1 – 5, how would you rate your health?
  (Awful) – 1   2   3   4   5 – (Great)

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
   - On a scale from 1 – 5, how much of the day do you spend thinking about food, eating and/or your weight?
     (Very little) – 1   2   3   4   5 – (All Day)
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? _______________
   - what kind? _______________

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? □Yes □No
   - Pain when urinating (peeing)? □Yes □No
   - Urinating very often in small amounts? □Yes □No
   - Bedwetting? □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 1 – 5, how often?
     (Never) 0   1   2   3   4   5 (Always)

F. School

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. How many days of school have you missed this year? ______________
6. Favorite part of school ____________________
   Least favorite ____________________
7. Are you having any problems in school? If yes, please explain: ________________ □Yes □No
   ____
   ____
8. List sports activities you are 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 / Social

1. List the people who live with you: ________________
2. Are you having any problems at home? If yes, please explain: ________________ ☐Yes ☐No
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? If yes, please explain: ☐Yes ☐No
   ____
10. Who do you talk to when you have a problem?
    ____
11. Are you going-out with anybody right now? ☐Yes ☐No
12. Is there any violence in any of your relationships? ☐Yes ☐No
    - If yes, with whom? ________________
13. Are you afraid of anyone? ☐Yes ☐No
    - If yes, who? ________________
14. Has anyone hurt you emotionally or physically? ☐Yes ☐No
    - If yes, who? ________________

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

Discussing topics such as sexuality, alcohol and drug use is sometimes difficult and embarrassing. The best way we can help you is if you are honest. Thank you.

J. Reproductive

Female:

1. Have you started your menstrual period? ☐Yes ☐No
   - If yes, at what age? ________
   - How many days does it last? ________
   - What is your flow usually like?
     ☐ Light ☐ Medium ☐ Heavy
2. What was the date of your last period? ________
   - Was it a normal period? ☐Yes ☐No
3. **Check (√) if you have:**
   - ☐ been pregnant
   - ☐ sores or lumps in vaginal area
   - ☐ had an abnormal pap smear
   - ☐ vaginal itching
   - ☐ had an abortion
   - ☐ vaginal odor
   - ☐ menstrual cramps
   - ☐ unusual vaginal discharge
   - ☐ pain with sex
   - ☐ Other ________
   - ☐ spotting or bleeding between periods
   - ☐ None
4. Have you had a pap smear and pelvic exam? ☐Yes ☐No
   - If yes, when and by whom?
   ____

Female / Male:

1. Have you ever had sex? ☐Yes ☐No
2. Whom have you had sex with?
   ☐ Males ☐ Females ☐ Both
3. What was your age when you first had sexual intercourse? ___________
4. How long have you been with your most recent sexual partner? ___________
5. How many sexual partners have you had in the last: 3 months? _________ 1 year? ____________
6. Do you use birth control? ☐Yes ☐No
   - What method? ____________________
7. On a scale of 1 – 5, how often do you use condoms?
   (Never) – 1 2 3 4 5 –(Always)
8. Has anyone ever touched you sexually or had sex with you when you didn't want them to? ☐Yes ☐No
   - If yes, when and by whom? ______________
   ____

Male:

Check (√) if you have:

☐ Crusting on tip of the penis when you wake up in the morning
☐ Difficulty starting to urinate (pee)
☐ Discharge from penis
☐ Ever gotten someone pregnant
☐ Sores on penis
☐ None

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/ huffing
☐ Diet pills	☐ Meth	☐ Speed/ crack
☐ Heroin	☐ PCP/Dust	☐ Steroids

☐ Other(s)_______________________________
____
____

L. On a scale of 1 to 5, how would you rate your life?
(Very Bad) – 1 2 3 4 5 – (Wonderful)

On a scale of 1 to 5, how do you feel most of the time?
(Very Sad) – 1 2 3 4 5 – (Very Happy)

Would you like to change your life? ☐Yes ☐No
If yes, what would you change? _______________
____
____

M. 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 both 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 ________________________
☐ Blood clots ______________________________
☐ Cancer _________________________________
- Breast _____________________________
- Ovarian ____________________________
- Uterine ____________________________
- Prostate ___________________________

☐ Diabetes ________________________________
☐ Ear infections ____________________________
☐ Eczema/Psoriasis___________________________
☐ Epilepsy/Seizures __________________________
☐ Gallbladder disease _________________________
☐ Hearing problems/Deafness ___________________
☐ Heart murmur_____________________________
☐ Heart problems/Heart attacks _________________
☐ High blood pressure ________________________
☐ High cholesterol____________________________
☐ Kidney problems/Bladder infections____________
☐ Learning problems__________________________
- ADD / ADHD___________________________
- Reading problems_______________________

☐ Liver problems_____________________________
☐ Mental illness ______________________________
- Depression__________________________
- Schizophrenia _______________________
- Bipolar_____________________________
-

Family History (continued)

- ☐ Migraine Headaches___________________________
- ☐ Obesity (overweight) __________________________
- ☐ Scoliosis (curvature of the spine)________________
- ☐ Sinus problems _______________________________
- ☐ Stroke _____________________________________
- ☐ Sudden deaths during exercise___________________
- ☐ Thyroid problems ____________________________
- ☐ Tuberculosis_________________________________
- ☐ Ulcers_____________________________________
- ☐ Vision problems:
  - Cataracts______________________________
  - Glaucoma _____________________________
  - Lazy eye ______________________________
- ☐ List any other illnesses that run your family: _______

____

____

N. Review of Systems

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

☐ Birthmarks/Moles	☐ High blood pressure
☐ Blurry vision/difficulty seeing / double vision	☐ Hoarse sounding voice
☐ Bruises easily	☐ Joint pain/ stiffness / swelling
☐ Chest pain with exercise	☐ Leg pain
☐ Crossed eyes	☐ Limp
☐ Difficulty breathing	☐ Lose balance sometimes
☐ Difficulty Hearing / Hearing loss	☐ Loss of eyesight
☐ Difficulty swallowing	☐ Mattery eyes
☐ Dizziness	☐ Nausea / Vomiting
☐ Drainage from or pain in ears	☐ Poor activity level/ get tired easily
☐ Dry skin	☐ Rashes
☐ Frequent bloody nose	☐ Red eyes
☐ Frequent cough	☐ Ringing in ears

Review of Systems (continued)

☐ Frequent runny / stuffy nose	☐ Scoliosis (crooked spine)
☐ Frequent sore throat	☐ Stomach cramps/pain
☐ Headaches	☐ Warts
☐ Heart murmur	☐ Wheeze or cough during / after exercise
☐ Other ___________________	☐ None

O. Active Community Services

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

- ☐ Public Health
- ☐ MFIP
- ☐ Spiritual
- ☐ Other ____

Reviewed by ____________________________________

(Medical Provider's signature)