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

SBHC Established Health History

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

Reason for today's visit: _____

Changes in personal health history? Yes No Changes in family health history? Yes No Physical in past 12 months? Yes No

Current Medications: None or List: _____ List any Allergies: None or List:_____

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: _____

_____

_____

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Client Signature: _____ Date: _____ Reviewed by: _____ Date: _____ Scanned _____