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

SBHC Initial Health History

Legal Name: ______________________________ **Birthdate:** ______________ **Today's Date:** ______________

Preferred Name:____________________ **Biological Sex:** M F **Preferred Pronouns:** he/him she/her they/them other

ALLERGIES to Medications: No Yes ______________________ **Current Gender Identity:** ________________________

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: Vape 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

SBHC Initial 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 short 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: ______________ Parent ___ Self___

Reviewed by: ____ Date: ______________

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

SBHC Established Health History

Legal Name ______________________________________ Birthdate_____________ Today's Date______________

Preferred Name _________________ **Preferred Pronouns** he/him she/her they/them other _________________

Biological Sex Male Female **Current Gender Identity** Male Female Other___________________________

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?

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____ Increased urine production

____ Increased thirst

Psychiatric

____ Anxiety

____ Problems with sleep

____ Depression

Other

____

____

____

____

____

Client Signature: ______________________ Date: _________ Reviewed by: ______________________ Date: ________ Scanned_____