MINNEAPOLIS SCHOOL BASED CLINICS program

Personal Health History

Minneapolis Health

Name _____ Preferred Name _____ Age ____ Date of Birth _____ Student ID # _____
Sex you were born as: ☐Male ☐Female Gender identity: ☐Male ☐Female ☐Other _____
Preferred Pronouns _____ School _____ Grade _____

PERSONAL HEALTH

1. Do you have allergies to ☐Medicine ☐Foods ☐Other _____ ☐No allergies
   If yes, what are you allergic to? _____ What kind of reaction? _____
2. Are you taking any medicine now? ☐Yes, name(s) _____ ☐No
3. What clinic/hospital do you go to? _____
4. Have you ever been in the hospital overnight? ☐Yes, reason _____ ☐No
5. Have you ever had an operation? ☐Yes, reason _____ date if known _____ ☐No
6. When was your last dental visit? _____ Name of dental clinic _____
7. Do you use a seat belt? ☐Yes ☐No
8. Do you wear a helmet on a bike, motorcycle, scooter or skateboard? ☐Yes ☐No ☐Don't use any of those

FAMILY HEALTH HISTORY

9. Who do you live with? _____
10. How many brothers (full, step, ½, adopted)? _____ How many sisters (full, step, ½, adopted)? _____
11. Name other family members who don't live with you who are very important to you _____
12. How are things at home? (Great) 5 4 3 2 1 (Not great at all)

13. Check any of these health problems that affect you or your family (brothers, sisters, parents, grandparents, aunts, uncles)

☐Alcohol/drug problems	☐Allergies	☐Anemia	☐Anxiety
☐Asthma	☐Blood clots	☐Cancer	☐Depression
☐Diabetes	☐Eating disorder	☐Heart problems	☐High blood pressure
☐High cholesterol	☐Kidney problems	☐Liver disease	☐Mental Health problems
☐Migraine headaches	☐Seizures/epilepsy	☐Sickle Cell disease/trait	☐Stroke

☐Other serious illness _____

14. What else should we know about your health or your family's health? _____

15. Is school a positive place for you? ☐Yes ☐No Why or why not? _____
16. How are your grades? A___ B___ C___ D___ F___
17. Have you had testing for a learning disability or been in Special Ed? ☐Yes ☐No IEP? ☐Yes ☐No
18. How often are you absent from school? ☐Often, # of days_____ ☐Rarely
19. Do you have a job? ☐Yes, where? _____ hours/week? _____ ☐No
20. Have you ever been suspended from school? ☐Yes, why? _____ ☐No

21. How well do you like yourself? ☐A lot ☐Mostly ☐Some ☐Not much ☐Not at all
22. Do you have a best friend or group of friends? ☐Yes ☐No
23. Who do you trust or talk to when things are not going well? ☐Yes _____ ☐No
24. Are you concerned about how you get along with family, friends or other people? ☐Yes _____ ☐No

25. Do you participate in cultural activities, groups, community activities, volunteer activities, religious/spiritual groups, sports or anything else? ☐Yes, what? _____ ☐No

26. Which of the following meals/snacks do you eat?
    ☐Breakfast ☐Morning snack ☐Lunch ☐Afternoon snack ☐Dinner ☐Evening snack
    Any special diet? ☐Yes, type _____ ☐No
    Are you concerned about food, diet or weight? ☐Yes _____ ☐No
27. Are you self-conscious about your body? ☐Yes _____ ☐No
28. Do you exercise? ☐Every day ☐Sometimes ☐Never
29. Do you have problems with sleep? ☐Yes _____ ☐No

Over the last 2 weeks, how often have you been bothered by any of the following problems?

30. Little interest or pleasure in doing things?
☐Not at all ☐Several days ☐More than half the days ☐Nearly every day
31. Feeling down, depressed or hopeless?
☐Not at all ☐Several days ☐More than half the days ☐Nearly every day
32. Do you feel stressed out, nervous, anxious or under a lot of pressure?
☐Not at all ☐Several days ☐More than half the days ☐Nearly every day
33. Have you ever thought about or tried to hurt yourself? ☐Yes ☐No
34. Have you ever been diagnosed with depression, anxiety, or other mental illness? ☐Yes ☐No
35. Have you ever been in: ☐Counseling ☐Treatment Center ☐Foster Home ☐Homeless Shelter ☐Group Home ☐JC/JD (Juvenile Correction/Detention ☐None

36. Do you use alcohol, tobacco, drugs? ☐Yes If yes, what are you using? _____ ☐No
37. Have you ever ridden in a car driven by someone (including yourself) who was drunk, high or had been using alcohol or drugs?
☐Yes ☐No

38. Have you been involved in or witnessed any violence in the last year? ☐Yes If yes, where? _____ ☐No
39. Has anyone physically, sexually or verbally hurt you or made you do something you didn't what to? ☐Yes ☐No
40. Has anyone forced you to have sexual activity that made you feel uncomfortable? ☐Yes ☐No

41. Who are you attracted to? ☐Males ☐Females ☐Both ☐Neither ☐Unsure
42. Have you ever had sex? ☐Yes If yes, how old were you the first time? _____ ☐No (skip to question 51)
43. When was the last time you had sex? _____
44. Who have you had sex with? ☐Males ☐Females ☐Both ☐Self
45. What types of sex have you had? ☐Penis-vagina ☐Oral ☐Anal (butt)
46. Do you use condoms/dental dams? ☐Always ☐Sometimes ☐Never
47. Do you use birth control? ☐Yes, what _____ ☐No
48. How many sexual partners have you had: in the last 2 months? _____ in the last year? _____ total? _____
49. Have you ever had a sexually transmitted infection? ☐Yes ☐No ☐Never been tested
If yes, which one(s)? ☐Chlamydia ☐Gonorrhea ☐HIV ☐Other (syphilis, herpes, warts, other_____)
Were you treated? ☐Yes and I took all my medicine ☐No Was your partner treated? ☐Yes ☐No
50. Have you ever been pregnant or gotten someone pregnant? ☐Yes, what did you do?_____ ☐No

51. Do you have concerns about your genital area (penis, vagina, butt)? ☐Yes, what _____ ☐No

FOR THOSE WHO MENSTRUATE

52. How old were you when you had your first period? _____ ☐Haven't had it yet
53. When was your last period? _____
54. Do you have a period every month? ☐Yes ☐No
55. Do you have any concerns about your periods? ☐Yes ☐No

56. Do you have any other concerns you would like to talk about today? ☐Yes _____ ☐No

Client signature: _____ Date: _____

Office use only
Comments:

Provider reviewed signature: _____ Date of service: _____