

Job Corps Health History Form

Your answers on this form will help Job Corps' health care providers get an accurate history of your medical concerns and conditions. These questions will help us get to know you better. This information is confidential. Please fill in all pages.

Diseases and Conditions

1. Have you ever had any of the following diseases or conditions?

Disease/condition	If yes, check this box	Disease/condition	If yes, check this box	Health and Wellness Center notes:
ADHD/ADD		High blood pressure		
Anemia/blood disorder		Joint pain/swelling		
Anxiety or panic attacks		Kidney/urine problem		
Asthma		Menstrual problem (F)		
Back problem/scoliosis		Mononucleosis		
Cancer		Seizures/epilepsy		
Chickenpox		Skin disorder		
Depression/suicide attempt		Sleep disorder/apnea		
Diabetes		Sports injury/fracture		
Headache/migraine		Stomach/bowel problem		
Head injury/concussion		Thyroid disorder		
Hearing loss		Tuberculosis		
Heart disease/murmur		Vision problems		
Hepatitis/liver disease		Weight problem		

Illnesses (circle yes or no)

2. Have you had a fever, rash, severe pain or cough in the past 2 weeks?*
- Yes No
3. Do you currently have any illnesses, problems, or concerns that you need to discuss today?*
- Yes No

Allergies

4. Do you have allergies to any of the following?

Allergen	List type (e.g., peanuts, dairy, specific medicine, cats)	Reaction (e.g., hives, trouble breathing)
Food		
Medicines or drugs		
Pollen, grass, hay fever, animals, or seasonal allergies		
Latex		

Student name: _____ Center: _____

DOB: _____ Gender: _____

ID #: _____ Race/ethnicity: _____

Medications

5. List all prescriptions and non-prescription medications, vitamins, supplements, home remedies, birth control, medications that help with your mood or behavior, herbs, inhalers, etc.

Medication	Dose (e.g., mg/pill)	How many times per day?	Reason

6. Have you stopped taking any medications in the past 3 months?* Yes No
7. Did you bring any medications with you?* Yes No

Surgical and Hospitalization History

8. Have you ever been in the hospital overnight? Yes No
9. Have you ever had surgery? Yes No
10. Have you decided not to have a recommended surgery? Yes No
11. Have you ever had a serious injury? Yes No

Family History

12. Has anyone in your family died for no apparent reason? Yes No
13. Has anyone in your family died of heart problems or of sudden death before age 50? Yes No
14. Does anyone in your family have :
- a. a heart problem, pacemaker or defibrillator? Yes No
 - b. Marfan syndrome? Yes No
 - c. high blood pressure, high cholesterol or diabetes? Yes No
 - d. cancer? Yes No
 - e. a history of mental health issues? Yes No
 - f. sickle cell disease? Yes No

Oral Health

15. In the past 2 weeks, have you had any untreated dental pain or swelling in the mouth that has interfered with sleeping, eating, or ability to function?* Yes No
16. Do you have braces or retainers? Yes No
17. Do you need to talk with someone about something related to your mouth today?* Yes No

Student name: _____ Center: _____

DOB: _____ Gender: _____

ID #: _____ Race/ethnicity: _____

Sports and Exercise

- | | | |
|--|-----|----|
| 18. Has a doctor ever denied or restricted your participation in sports? | Yes | No |
| 19. Have you ever passed out, or nearly passed out during or after exercise? | Yes | No |
| 20. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? | Yes | No |
| 21. Does your heart ever race or skip beats (irregular beats) during exercise? | Yes | No |
| 22. Has your doctor ever told you have any heart problems (such as high blood pressure, high cholesterol, a heart murmur, or heart infection)? | Yes | No |
| 23. Has a doctor ever ordered a test for your heart (i.e., EKG or echocardiogram)? | Yes | No |
| 24. Do you get lightheaded or feel more short of breath than expected during exercise? | Yes | No |
| 25. Have you ever had a seizure? | Yes | No |
| 26. Do you get more tired or short of breath more quickly than friends during exercise? | Yes | No |

Eating and Weight

- | | | |
|---|-----|----|
| 27. In the past year, have you tried to lose weight or control your weight by vomiting, taking diet pills or laxatives? | Yes | No |
| 28. Have you ever been diagnosed with an eating disorder (e.g., bulimia, anorexia, binge eating disorder)? | Yes | No |

Mental Health and Well Being

- | | | |
|--|-----|----|
| 29. Have you had serious thoughts of suicide or have you tried to end your life recently?* | Yes | No |
| 30. Have you tried to hurt yourself by cutting, burning, or any other way recently?* | Yes | No |
| 31. Are you feeling like you might physically hurt someone?* | Yes | No |
| 32. Are you currently feeling stressed out and need to talk with someone <u>today</u> ?* | Yes | No |

Alcohol, Drugs, and Tobacco

- | | | |
|--|-----|----|
| 33. In the past 2 weeks, have you used alcohol or used drugs frequently or daily?* | Yes | No |
| 34. Have you ever smoked cigarettes or used tobacco products? | Yes | No |
| 35. Would you like to speak with someone about your alcohol or drug use? | Yes | No |

Sexual History

- | | | | | |
|---|-----------|--------|-------|-----|
| 36. Have you ever had sex? | Yes | No | | |
| 37. Are you currently involved in a sexual relationship? | Yes | No | | |
| 38. What best describes your past sexual partners? | Male | Female | Both | N/A |
| 39. Have you ever been pregnant or gotten someone pregnant? | Yes | No | | |
| 40. How often do you use condoms when you have sex? | Sometimes | Always | Never | |
| 41. Have you ever had a sexually transmitted infection or disease (e.g., Chlamydia, gonorrhea)? | Yes | No | | |
| 42. Are you currently using any kind of birth control (e.g., birth control pills, Depo Provera, the ring, IUD, Implanon)? | Yes | No | | |
| 43. Have you discussed birth control with your partner (if applicable)? | Yes | No | | |
| 44. Would you like to receive birth control? | Yes | No | | |

Student name: _____ Center: _____

DOB: _____ Gender: _____

ID #: _____ Race/ethnicity: _____

Female's Health History

45. Total number of pregnancies: _____ Number of births: _____

46. Date (month/day) of last menstrual period: _____

47. How would you describe your period? _____ Heavy Medium Light

48. How many days does your period last? _____

49. Do you get cramps or experience pain during your period? _____ Yes No

Other

50. Please describe any other health problems that we should know about.

Student signature

Date

For Health and Wellness Center use only.

Nurse notes: All affirmative responses to questions denoted with an asterisk (*) must be addressed. Additional notable responses should be addressed.

Signature of nurse who reviewed above with student

Date

Practitioner: Address any affirmative responses by number.

Practitioner signature

Date

Student name: _____

Center: _____

DOB: _____

Gender: _____

ID #: _____

Race/ethnicity: _____