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?

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

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?

<table>
<thead>
<tr>
<th>Allergen</th>
<th>List type (e.g., peanuts, dairy, specific medicine, cats)</th>
<th>Reaction (e.g., hives, trouble breathing)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicines or drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pollen, grass, hay fever, animals, or seasonal allergies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Latex</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose (e.g., mg/pill)</th>
<th>How many times per day?</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 today?*  
   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:** ___________________________________________