**Job Corps Health History Form**

**Instructions:** Welcome to Job Corps Health and Wellness. We know you provided some health information before arriving and now that you are here, we want to make sure we understand your health so we can meet your needs. Some of the questions may seem similar. Your answers on this form will help Job Corps’ healthcare 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.

**Part 1: Medical History**

***Conditions***

1. Have you ever had any of the following conditions: (circle all that apply)

|  |  |  |  |
| --- | --- | --- | --- |
| ADHD/ADD | Headache/migraine | Kidney/urine problem | Sports injury |
| Anemia/blood disorder | Head injury/concussion | Mental health issues | Stomach/bowel problem |
| Asthma | Hearing loss | Mononucleosis | Substance use issues |
| Back problem/scoliosis | Heart disease/murmur | Mouth or teeth issues | Thyroid disorder |
| Broken bone | Hepatitis/liver disease | Seizures/epilepsy | Tuberculosis |
| Cancer | High blood pressure | Skin disorder | Vision problems |
| Diabetes | Joint pain/swelling | Sleep problems | Weight issues |

1. Describe any other health problems that we should know about.
2. List any health problems or diseases that run in your family.

***Allergies***

1. Do you have allergies to any of the following? (circle all that apply)

Food Medicines or drugs Pollen/grass/seasonal allergies Animals Milk/lactose Latex Metals

Other (specify):

If you have an allergy, tell us more about it. What triggers the allergy? What happens if you’re exposed?

***Medications***

1. List all prescription and non-prescription medications, vitamins, supplements, home remedies, birth control, herbs, inhalers, or other medications that help with your mood or behavior (attach extra pages if needed).

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Medication** | **Dose (e.g., mg/pill)** | **How many times per day?** | **Reason** | | |
|  |  |  |  | | |
|  |  |  |  | | |
|  |  |  |  | | |
| 1. Have you stopped taking any medications in the past 3 months? | | | | Yes | No |
| 1. Did you bring any medications with you? | | | | Yes | No |

***Surgical and Hospitalization History***

|  |  |  |
| --- | --- | --- |
| 1. Have you ever been in the hospital overnight? | Yes | No |
| 1. Have you ever had surgery? | Yes | No |

**Part 2: Health Behaviors**

***Health Behaviors, Unhealthy Behaviors, and Safety Issues***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1. How would you rate your sleep? | Excellent | Good | | Fair | | Poor |
| 1. How would you rate your healthy eating habits? | Excellent | Good | | Fair | | Poor |
| 1. Have you been trying to gain or lose weight? | | | Yes | | No | |
| 1. Do you drink soda, pop, or sports drinks daily? | | | Yes | | No | |
| 1. Do you brush your teeth at least twice a day? | | | Yes | | No | |
| 1. Do you floss your teeth at least once a day? | | | Yes | | No | |
| 1. When playing sports, do you wear a mouthguard? | | | Yes | | No | |
| 1. Have you seen a dentist in the last 12 months or sooner? | | | Yes | | No | |
| 1. Do you always wear a seatbelt when in a car? | | | Yes | | No | |
| 1. Do you have access to guns when at home?    1. If yes, are they kept in a lock box? | | | Yes  Yes | | No  No | |
| 1. Do you ever carry weapons? | | | Yes | | No | |
| 1. Has anyone ever touched you physically or sexually when you didn’t want them to? | | | Yes | | No | |
| 1. Has a close friend or partner ever hit, punched, or kicked you? | | | Yes | | No | |
| 1. Have you ever vaped, smoked, or used nicotine products? | | | Yes | | No | |
| 1. Do you use alcohol? | | | Yes | | No | |
| 1. Do you use drugs? | | | Yes | | No | |

***Sexual History***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1. Have you ever had sex? (Skip to 31 if the answer is “no.) | | | Yes | | No |
| 1. Are you currently involved in a sexual relationship? | | | Yes | | No |
| 1. What best describes your past sexual partners? | Male | Female | Both | | N/A |
| 1. How often do you use condoms when you have sex? | Never | Sometimes | Always | | N/A |
| 1. Have you ever had a sexually transmitted infection or disease (e.g., Chlamydia, gonorrhea)? | | | Yes | | No |
| 1. Do you use any of the following? (circle all that apply) None Birth control pills *Depo Provera* Ring IUD  Nexplanon Condoms Pull out/withdrawal Patch Other: | | | | | |
| 1. Would you like to discuss or receive birth control? | | | Yes | No | |

***Reproductive Health History***

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | 1. Have you ever been pregnant or gotten someone else pregnant? | | | | | Yes | No | | If yes: | Total number of pregnancies: | Number of births: | | | | | | **For females with periods:** | | | | | | | | Date (month/day) of last menstrual period: | | | | | | | | 1. How would you describe your period? | | | Heavy | Medium | Light | | | How many days does your period last? | | | | | | | | 1. Do you get cramps or experience pain during your period? | | | | | Yes | No | |

**Part 3: Sports Clearance**

|  |  |  |
| --- | --- | --- |
| 1. What types of sports or exercise do you enjoy? |  |  |
| 1. Has a doctor ever denied or restricted your participation in sports? | Yes | No |
| 1. Have you ever passed out, or nearly passed out during or after exercise? | Yes | No |
| 1. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? | Yes | No |
| 1. Does your heart ever race or skip beats (irregular beats) during exercise? | Yes | No |
| 1. Has your doctor ever told you that you have any heart problems (such as high blood pressure, high cholesterol, or a heart murmur)? | Yes | No |
| 1. Has a doctor ever ordered a test for your heart (i.e., EKG or echocardiogram)? | Yes | No |
| 1. Do you get lightheaded or feel shorter of breath than expected during exercise? | Yes | No |
| 1. Do you get tired or short of breath more quickly than friends during exercise? | Yes | No |
| 1. Are you aware of anyone in your family dying for no apparent reason? | Yes | No |
| 1. Are you aware of anyone in your family with heart problems or of sudden death before age 50? | Yes | No |

**Part 4: Pressing Needs**

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Have you had the following in the past **2 weeks**? (circle all that apply)   Fever Rash Severe pain Cough Daily alcohol or drug use  Severe dental pain Swelling in the mouth, cheek, jaw, or neck | | | |
| 1. Have you **ever** had the following? (circle all that apply)   Thoughts of suicide Suicide attempt Hurting yourself by cutting, burning, or some other way  Feeling like you may hurt someone else | | | |
| 1. Do you need to speak with a member of our health and wellness staff urgently? | Yes | No | Not sure |
| 1. If yes, who do you think could best help you? (circle all that apply)   Physician Nurse Mental Health Dentist Substance abuse counselor | | | |

1. Depression (circle the box that applies)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Over the past two weeks, how often have you been bothered by the following problems?** | **Not at all** | **Several days** | **More than half of the days** | **Nearly every day** |
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 1. Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |

**Student signature Date**

|  |
| --- |
| **For Health and Wellness Center use only.** |
| Nurse notes: Address any affirmative responses by number.  Action items.  Referral to the following:  PHYSICIAN REFERRAL  MENTAL HEALTH REFERRAL  OFF-CENTER DENTIST REFERRAL  TEAP REFERRAL  HEALS REFERRAL    Signature of nurse who reviewed above with student Date |
| Practitioner: Address any affirmative responses by number.  Document educational counseling provided and f/u plan:      Practitioner signature Date |