Today's Date: __________

Ballard Teen Health Center - Health History

Last Name:	First Name:	Date of Birth:	Gender:
What school do you attend? ☐ Ballard High School ☐ The Center School		Student ID Number:	
Address:	City:	State:	Zip:
Home Phone:	Parent Cell Phone:		
Parent/Guardian Name:	Relationship:	Contact Number:	
Does the student have a permanent place to live? ☐Yes ☐ No			
What is the student's preferred language?	Family language?		
Is the student eligible for Free or Reduced Lunch Program? ☐ Yes ☐No	Are you enrolled in the Medicaid program? ☐ Yes ☐ No		

MEDICAL HISTORY

Does the student have any medical problems or mental health concerns?	☐ Yes	☐ No
Does the student need medication on a regular basis? If so, what: ____________________	☐ Yes	☐ No
Has the student ever had had any surgery, serious illness or injury?	☐ Yes	☐ No
Does the student have any allergies to medications? If so, what: _____________________	☐ Yes	☐ No
Does the student have any allergies to foods? If so, what: ____________________________	☐ Yes	☐ No
Does the student have a Primary Care Provider? Date of Last Check up: _________________	☐ Yes	☐ No
Does the student have a Dentist? Date of Last Check up: _____________________________	☐ Yes	☐ No
Does the student have a therapist? Name: ______________________ Number: ___________	☐ Yes	☐ No

Has the student had any of the following? If so, please check the box

☐ Arthritis	☐ Depression	☐ Hepatitis	☐ Asthma
☐ Anemia	☐ ADHD	☐ Broken Bone	☐ Seizure
☐ Anxiety	☐ Eating Disorder	☐ Thyroid Condition	☐ Positive TB Test
☐ Felt Suicidal	☐ Heart Disease	☐ Knee or ankle injury	☐ Chicken Pox
☐ Attempted suicide	☐ Learning Disability	☐ Blood Transfusion	☐ Been knocked out/unconscious
☐ Psychiatric Hospitalization	☐ Diabetes	☐ Head or Neck Injury/Concussion	☐ Urinary Tract Infection
☐ Passed out or gotten dizzy while exercising	☐ Had breathing problems during exercise		

FAMILY HEALTH HISTORY

Has anyone in the student's family had the following? If so, Please write in which family member

	Parent	Parent	Grandparent	Grandparent	Details
Asthma	☐	☐	☐	☐	
Diabetes	☐	☐	☐	☐	
Heart Problems/Stroke	☐	☐	☐	☐	
Heart attack prior to the age of 50	☐	☐	☐	☐	
Depression	☐	☐	☐	☐	
Bipolar Disorder	☐	☐	☐	☐	
Anxiety	☐	☐	☐	☐	
Suicide History	☐	☐	☐	☐	
Other mental health concerns	☐	☐	☐	☐	
Alcohol or Substance Abuse	☐	☐	☐	☐	
Cancer	☐	☐	☐	☐	
Seizures	☐	☐	☐	☐	
High Blood Pressure	☐	☐	☐	☐	
High Cholesterol	☐	☐	☐	☐	

SCHOOL

Does your student like school? ☐ Yes ☐ No

What are your student's favorite classes and activities? ____

Is there anything your student struggles with at school? ☐ Yes ☐ No

Has the student ever had an IEP or 504 plan? ☐ Yes ☐ No