TCAPS STUDENT HEALTH CENTER
IN PARTNERSHIP WITH NORTHWEST MICHIGAN HEALTH SERVICES INC

STUDENT HEALTH HISTORY FORM

GENERAL INFORMATION:	
Patient Name:	DOB:
Primary Care Physician: PH#: *Date last seen:* *Date of last well child/physical:*	Dental Home: PH#: *Date last seen:* *Date of last exam:*

STUDENT MEDICAL HISTORY: HAS THE STUDENT HAD ANY OF THE FOLLOWING? IF YES, CHECK ALL THAT APPLY.

ADD/ADHD or Learning Disability (IEP?)	☐Asthma or Shortness of Breath	☐Cancer
☐ Anemia or Bleeding Disorder	☐Autism/Autism Spectrum Disorder	☐Diabetes
☐Eye Problems (glaucoma/impaired vision)	☐Bladder or Kidney Problems or Infections	☐Digestive Problems
☐Headaches or Migraines	☐Heart Problems (high blood pressure/congenital heart defect/rheumatic fever/irregular heartbeat)	☐Hearing Problems
☐Liver Problems (hepatitis/jaundice)	☐Neurological Problems (cerebral palsy/seizures/brain injury)	☐Scoliosis
☐Mood Difficulties (depression/anxiety/suicidal thoughts/self-harm/eating disorder)	☐Respiratory Problems (sleep apnea/snoring/ cystic fibrosis)	☐Thyroid Problems
☐Premature Birth or Birth defects	☐Sickle Cell Disease or Trait	☐Skin Problems (acne, rash)
☐Sports Injuries/Broken Bones/Injury to Face or Teeth	☐Sexually Transmitted Infections (HIV/AIDS/gonorrhea/chlamydia/ trichomonas)	☐Infectious Disease (recurrent sinusitis/measles/mumps/ mononucleosis/pneumonia/meningitis/scarlet fever/chicken pox/TB/strep)

Surgeries & Dates:	List of all current medications & vitamins?	Allergies/Reactions:

STUDENT SOCIAL HISTORY

Has the student ever had drug/alcohol abuse? ☐ No ☐ Yes **If yes:** ☐ current problem ☐ receiving treatment ☐ recovering	Does the student feel safe at home? ☐ No ☐ Yes
Does the student use any marijuana products? ☐ No ☐ Yes **If yes:** ☐ Smoke ☐ Vape ☐ Edibles	Does the student use tobacco products? ☐ No ☐ Yes **If yes:** _____day X _____ yrs ☐ cigarettes ☐ vape ☐ chew

What does the student drink throughout the day: ☐ Pop ☐ Diet Pop ☐ Coffee/Tea ☐ Juice ☐ Water ☐ Energy Drinks ☐ Alcohol

FAMILY MEDICAL HISTORY: ANY MEMBER OF THE STUDENT'S FAMILY (MOTHER, FATHER, SIBLINGS, AUNT, UNCLES, GRANDPARENTS) EVER HAD ANY OF THE FOLLOWING? **IF YES, CHECK ALL THAT APPLY AND LIST WHO (MOTHER, FATHER, ETC.)**

☐Birth Defect Relationship:	☐Diabetes Relationship:	☐Immune Suppression/HIV/AIDS Relationship:	☐Liver Disease/Hepatitis Relationship:	☐Seizures Relationship:
☐Thyroid Disease Relationship:	☐Blood/Bleeding Disorders Relationship:	☐Heart Disease (premature death/high blood pressure) Relationship:	☐Kidney/Urine Disease Relationship:	☐Lung Disease (COPD/asthma/other) Relationship:
☐Skin Disorder Relationship:	☐Tuberculosis Relationship:	☐Cancer Relationship:	☐High Cholesterol Relationship:	☐Learning Disability Relationship:
☐Mood Problems Relationship:	☐Stomach Problems Relationship:		☐Other Relationship:	

_____ _____ _____

Signature of Parent/Guardian/Patient age 18 and older | Print Name | Date

Revised: 05/25/2021