Three Rivers Health
PAWS Community Adolescent Health Center (CAHC) and E3 Program

STUDENT AND FAMILY MEDICAL HISTORY FORM

NAME: _____ **DOB:** _____

STUDENT MEDICAL HISTORY:

When was your last eye examination? Do you wear glasses? Yes No If Yes, who is your eye doctor?		
When was your last dental appointment? Who is your dentist?		
Bee Sting Allergies? Yes No Do you have an EpiPen Yes No	Overnight Hospitalizations? Yes No Reason:	
Medication Allergies? Yes No Type:	Surgeries? Yes No Type:	Have you had any problems with childhood vaccines? Yes No Type: Reaction:
Food Allergies? Yes No Type:	Allergies: (hay fever, dust, pollen) Yes No Type:	
Daily medications? Yes No If Yes, please list.		
Asthma? Yes No	Kidney Disease? Yes No	Seizures (epilepsy)? Yes No
Diabetes? Yes No	Painful Joints? Yes No	Anemia? Yes No
Eczema/Rashes? Yes No	Pounding of Heart? Yes No	Stomach problems? Yes No
Headaches/Migraines? Yes No	Shortness of Breath? Yes No	Heart problems / murmur? Yes No
ADD/ADHD? Yes No	Frequent Urination? Yes No	Bladder problems? Yes No
High Blood Pressure? Yes No	Nosebleeds? Yes No	Pneumonia? Yes No
Sickle cell trait or disease Yes No	Frequent Sore Throats? Yes No	Have you had chickenpox? Yes No *If yes, please provide month and year*
Fainting? Yes No	Backaches? Yes No	
Other Health Concerns? Yes No		

PLEASE COMPLETE THE NEXT PAGE

FAMILY MEDICAL HISTORY:

Please indicate with an *X* family members who have had any of the following conditions:

	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad's	Dad's Mom	Dad's Dad	Mom's Sister	Mom's Brother	Dad's Sister	Dad's Brother
ADHD/ADD												
Alcoholism												
Anemia												
Arthritis												
Asthma												
Autism / Asperger's												
Autoimmune Disorder												
Birth Defect/Congenital Anomaly												
Bleeding Problem												
Blood Clots												
Cancer (Breast)												
Cancer: please specify												
Celiac Disease (gluten allergy)												
Depression / Anxiety												
Congestive Heart Failure												
COPD/Emphysema												
Diabetes												
Dementia												
Eczema												
Epilepsy (Seizure Disorder)												
Heart Attack/Coronary Artery Disease												
High Cholesterol												
Heart Murmur												
High Blood Pressure												
Immune Disorder												
Inflammatory Bowel Disease												
Kidney Disease												
Learning Disability												
Liver Disease												
Migraine Headaches												
Obesity												
Osteoporosis												
Psychiatric/Mental Illness												
Scoliosis												
Stroke												
Substance Abuse												
Thyroid Disease												
Tobacco Use												
Tuberculosis												
Ulcers												
Death before age 56												
Other:												
Other:												

_____

Parent/Guardian Signature

Reviewed with client: _____ _____

Initials Date