MINNEAPOLIS SCHOOL BASED CLINICS program

Personal Health History

Minneapolis Health

Legal Name:		Preferred Name:
Date of Birth:	Age:	Pronouns (she/her, he/him, other):
Sex assigned at birth: ☐Male ☐Female		Gender Identity (female, male, other):
School:	Grade:	Student ID #:

PERSONAL HEALTH

1. Allergies (medicine, food, other):	☐None
2. Medications (prescription, over-the-counter, supplements):	☐None
3. Hospitalization and surgery/ operation history:	☐None
4. What medical clinic/hospital do you go to?	☐None
5. What dental clinic do you go to?	☐None

MEDICAL HISTORY

6. Check any of these health problems that affect you or your family (brothers, sisters, parents, grandparents, aunts, uncles)

• Allergies	☐You ☐Family	• Heart disease	☐You ☐Family
• Anemia	☐You ☐Family	• Hepatitis / Liver disease	☐You ☐Family
• Anxiety	☐You ☐Family	• Hypercholesterolemia (High cholesterol)	☐You ☐Family
• Asthma	☐You ☐Family	• Hypertension (High blood pressure)	☐You ☐Family
• Blood clots	☐You ☐Family	• Renal / Kidney disease	☐You ☐Family
• Cancer	☐You ☐Family	• Seizures / epilepsy	☐You ☐Family
• Depression	☐You ☐Family	• Sickle cell disease/ trait	☐You ☐Family
• Diabetes	☐You ☐Family	• Stroke	☐You ☐Family
• Headache / Migraine	☐You ☐Family	• Other serious illness	☐You ☐Family

What else should we know about your health or your family's health?

We ask every patient these questions about things that can affect your health and well-being. Some of the questions might not fit you. It is okay to leave some questions blank. Your answers are private.

7. Do you have any concerns you would like to talk about today?

SOCIAL HISTORY

8. Who do you live with?	
9. Do you ever worry about money, a place to live, food, or clothing?	☐ Yes ☐ No ☐ Sometimes
10. Have you ever been in a: Treatment center; Foster home; Homeless shelter; Group home; JC/JD (Juvenile Correction/Detention); Other group living/ displacement?	☐ Yes ☐ No ☐ Sometimes
11. Is school a positive place for you?	☐ Yes ☐ No ☐ Sometimes
12. How are your grades?	☐ A ☐ B ☐ C ☐ D ☐ F
13. Have you had testing for a learning disability or been in Special Ed or IEP?	☐ Yes ☐ No ☐ Sometimes
14. Have you missed more than 7 days of school in the last year?	☐ Yes ☐ No ☐ Sometimes
15. Do you have a job?	☐ Yes ☐ No ☐ Sometimes
16. Have you ever been suspended from school?	☐ Yes ☐ No ☐ Sometimes

DAILY ACTIVITIES

17. Which of the following meals/snacks do you eat?	☐Breakfast ☐Morning snack ☐Lunch ☐Afternoon snack ☐Dinner ☐Evening snack
18. Are you trying to or has anyone recommended that you gain or lose weight?	☐ Yes ☐ No ☐ Sometimes
19. Are you self-conscious about your body?	☐ Yes ☐ No ☐ Sometimes
20. Do you get 60 minutes of physical activity most days of the week?	☐ Yes ☐ No ☐ Sometimes
21. Do you have problems with sleep?	☐ Yes ☐ No ☐ Sometimes

RISK/SAFETY

22. Do you use a seatbelt in a car/ truck?	☐ Yes ☐ No ☐ Sometimes
23. Do you wear a helmet when you skateboard, bicycle, motorcycle, snowmobile, ATV?	☐ Yes ☐ No ☐ Sometimes
24. Do you feel safe at home, at school, and in your community?	☐ Yes ☐ No ☐ Sometimes
25. Do you or anyone you live with have a gun or carry a gun around?	☐ Yes ☐ No ☐ Sometimes

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RISK/SAFETY	
26. Have you been involved in or witnessed any violence in the last year?	☐ Yes ☐ No ☐ Sometimes
27. Has anyone physically, sexually, or verbally hurt you?	☐ Yes ☐ No ☐ Sometimes
28. Have you ever ridden in a car/truck driven by someone (including yourself) who was drunk, high, or had been using alcohol or drugs?	☐ Yes ☐ No ☐ Sometimes

SUBSTANCE USE				
29. In the past year, how many times have you used:				
a. Tobacco (cigarettes, cigars, chew)	☐ Never	☐ Once or twice	☐ Weekly	☐ Daily
b. Vaping nicotine (e-cigarettes)	☐ Never	☐ Once or twice	☐ Weekly	☐ Daily
c. Alcohol	☐ Never	☐ Once or twice	☐ Weekly	☐ Daily
d. Marijuana (weed, cannabis, THC, edibles)	☐ Never	☐ Once or twice	☐ Weekly	☐ Daily
e. Anything else to get high (like other illegal drugs, prescription or over-the-counter medications, and things that you sniff, huff, or vape)	☐ Never	☐ Once or twice	☐ Weekly	☐ Daily What?

PSYCHOSOCIAL HISTORY				
30. In general are you happy with the way things are going for you?	☐ Yes ☐ No ☐ Sometimes			
31. Over the past 2 weeks, how often have you been bothered by any of the following problems?				
a. Feeling nervous, anxious, or on edge	☐ Not at all	☐ Several days	☐ Over half the days	☐ Nearly every day
b. Not being able to stop or control worrying	☐ Not at all	☐ Several days	☐ Over half the days	☐ Nearly every day
c. Little interest or pleasure in doing things	☐ Not at all	☐ Several days	☐ Over half the days	☐ Nearly every day
d. Feeling down, depressed, or hopeless	☐ Not at all	☐ Several days	☐ Over half the days	☐ Nearly every day
32. Have you ever hurt or cut yourself on purpose?	☐ Yes ☐ No ☐ Sometimes			
33. Do you ever think about killing yourself or wish you were dead?	☐ Yes ☐ No ☐ Sometimes			
34. Have you had any stressful or scary events that still bother you?	☐ Yes ☐ No ☐ Sometimes			
35. Have you ever been in counseling or mental health therapy?	☐ Yes ☐ No ☐ Sometimes			

SEXUAL HEALTH	
36. Who are you attracted to (males, females, both, neither, unsure, other)?	
37. Have you ever had any kind of sex with another person?	☐ Yes ☐ No ☐ Sometimes
38. How old were you the first time you had sex?	
39. When was the last time you had sex?	
40. What types of sex have you had?	☐ Oral ☐ Penis in Vagina ☐ Penis in Anus (Butt) ☐ Other:
41. How do you prevent pregnancy?	☐ Condoms ☐ Birth Control: ☐ Other:
42. How do you prevent sexually transmitted infections?	☐ Condoms ☐ Dental Dams ☐ Other:
43. Have you ever had an infection spread by sex?	☐ Chlamydia ☐ Gonorrhea ☐ Trichomoniasis ☐ Syphilis ☐ Herpes ☐ Genital warts ☐ Pelvic inflammatory disease (PID) ☐ HIV ☐ Other:
44. Have you ever been pregnant or gotten someone pregnant?	☐ Yes ☐ No
45. Have you ever traded sex for money, food, a place to live, or anything else?	☐ Yes ☐ No ☐ Sometimes
46. Has anyone ever forced you to do something sexually that you did not want to do or that made you uncomfortable?	☐ Yes ☐ No ☐ Sometimes
47. Do you have concerns about your genital area (penis, vagina, butt)?	☐ Yes ☐ No ☐ Sometimes

FOR THOSE WHO MENSTRUATE / HAVE A PERIOD	
48. How old were you when you had your first period?	☐ Haven't had it yet
49. When was your last period?	
50. Do you have a period every month?	☐ Yes ☐ No ☐ Sometimes
51. Do you have any concerns about your period?	☐ Yes ☐ No ☐ Sometimes

Client signature: _____ Date: _____

Provider reviewed signature: _____ Date of service: _____