



HEALTH-RELATED HISTORY FORM

This form is to be completed by a licensed health care professional.

Name of Youth: _____
Full Name _____ DJJID# _____

Date of Birth _____ Age When Form Completed _____ Sex _____ Race _____

I. ALLERGIES

A. FOOD	B. ENVIRONMENTAL	C. MEDICATION

Special Diet: _____

Yes **No**
 Are you taking medication? (Where are your meds now?) _____
 Has the youth required an EpiPen? _____

MEDICATION	DOSAGE	FREQUENCY	LAST DATE OF USE

Yes **No**
 Do you have glasses or contact lenses?
 Are you hurting or injured anywhere right now? _____
 Do you have any bruises/lacerations/breaks in the skin? _____
 Do you have any major medical conditions? _____
 Have you recently been around anyone, or infected with, Chicken Pox, Hepatitis, TB or MRSA? _____
 Who is your family physician/clinic? _____
 Have you seen a dentist within the last six months? If so, what treatment? _____

Personal and Family History - Have you or your family had any of the following? Answer all questions. Family includes Father, Mother, Brothers, Sisters, and Grandparents.

D. PERSONAL AND FAMILY HISTORY					
(Check all that apply)					
	Family	Self Only		Family	Self Only
ADHD		<input type="checkbox"/>	Mononucleosis (date) _____		<input type="checkbox"/>
Antibiotics - Dental Work (due to heart defects)		<input type="checkbox"/>	Pregnancy _____		<input type="checkbox"/>
Back Problems		<input type="checkbox"/>	Recurrent Bladder Infections		<input type="checkbox"/>
Blood Clot/Phlebitis		<input type="checkbox"/>	Recurrent Diarrhea		<input type="checkbox"/>
Chicken Pox		<input type="checkbox"/>	Rheumatic Fever		<input type="checkbox"/>
Ear, Nose and Throat Trouble		<input type="checkbox"/>	Scoliosis		<input type="checkbox"/>
Eye Trouble		<input type="checkbox"/>	Sexually Transmitted Diseases (STDs)		<input type="checkbox"/>
Head Injury with Unconsciousness		<input type="checkbox"/>	Skin Diseases (acne, eczema, psoriasis)		<input type="checkbox"/>
Hospitalizations/Surgery (specify) _____		<input type="checkbox"/>	Strep Throat		<input type="checkbox"/>
			TMJ (jaw problems)		<input type="checkbox"/>
			Transfusions (date) _____		<input type="checkbox"/>
Hypoglycemia		<input type="checkbox"/>	Varicose Veins		<input type="checkbox"/>
Malaria (date) _____		<input type="checkbox"/>	Other Chronic Conditions		<input type="checkbox"/>



FLORIDA DEPARTMENT OF JUVENILE JUSTICE

D. PERSONAL AND FAMILY HISTORY					
(Check all that apply)					
	Family	Self Only		Family	Self Only
Alcohol/Drug Dependency	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur/Disease	<input type="checkbox"/>	<input type="checkbox"/>
Allergy, Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Anemia/Blood disease/Sickle Cell Anemia/ Trait	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease/Infections	<input type="checkbox"/>	<input type="checkbox"/>
Anorexia Nervosa	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease/Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Obesity	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Peptic Ulcer Disease	<input type="checkbox"/>	<input type="checkbox"/>
Bulimia	<input type="checkbox"/>	<input type="checkbox"/>	Suicidal Ideation	<input type="checkbox"/>	<input type="checkbox"/>
Cancer, Cyst, Tumor	<input type="checkbox"/>	<input type="checkbox"/>	Other Psychological Problems	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy, Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>
Gallbladder Trouble	<input type="checkbox"/>	<input type="checkbox"/>			

Family History:

Father:	<input type="checkbox"/> Living	<input type="checkbox"/> Deceased	Age at Death:	Cause:
Mother:	<input type="checkbox"/> Living	<input type="checkbox"/> Deceased	Age at Death:	Cause:

Review of Systems: Indicate any current symptoms the youth has from the list below:

Constitutional/Endocrine	Genitourinary	Musculoskeletal
<input type="checkbox"/> Fever/chills/excessive sweating	<input type="checkbox"/> Bedwetting	<input type="checkbox"/> Muscle/joint pain or swelling
<input type="checkbox"/> Unexplained weight loss/gain	<input type="checkbox"/> Blood in the urine	Skin
<input type="checkbox"/> Feeling tired a lot	<input type="checkbox"/> Discharge from penis or vagina	<input type="checkbox"/> Rashes or itching
Eyes	<input type="checkbox"/> Itching	<input type="checkbox"/> Acne
<input type="checkbox"/> Blurry Vision	<input type="checkbox"/> Pain with urination	<input type="checkbox"/> Unusual moles
Ears/Nose/Throat	<input type="checkbox"/> Problems with periods (females)	Psychiatric/Emotional
<input type="checkbox"/> Trouble with hearing	Neurological	<input type="checkbox"/> Speech problems
<input type="checkbox"/> Mouth breathing/snoring	<input type="checkbox"/> Headaches	<input type="checkbox"/> Anxiety/stress
<input type="checkbox"/> Frequent runny nose	<input type="checkbox"/> Fainting/Dizziness	<input type="checkbox"/> Sleep problems/nightmares
<input type="checkbox"/> Frequent sore throat	<input type="checkbox"/> Excessive Drowsiness	<input type="checkbox"/> Depression/feeling sad
<input type="checkbox"/> Problems with teeth/gums	Allergy	<input type="checkbox"/> Nail biting
Respiratory	<input type="checkbox"/> Hay fever/itchy eyes	<input type="checkbox"/> Bad temper/angry outbursts/feeling moody
<input type="checkbox"/> Cough/wheeze	<input type="checkbox"/> Frequent sneezing or stuffy nose	<input type="checkbox"/> Cutting, Hurting Self
Gastrointestinal	Cardiovascular	<input type="checkbox"/> Learning difficulties
<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Tire easily with exertion*	Blood/Lymph
<input type="checkbox"/> Nausea/vomiting/diarrhea	<input type="checkbox"/> Shortness of breath*	<input type="checkbox"/> Unexplained lumps
<input type="checkbox"/> Constipation	<input type="checkbox"/> Palpitations (irregular heart beat) *	<input type="checkbox"/> Easy bruising/bleeding
	<input type="checkbox"/> Chest pain	

* School Physical Activity Clearance Form: Use Physical Activity Clearance if there are any symptoms identified in CVS Section.

Reproductive Health:

Male and Females:	Yes	No
Have you ever had sex before?	<input type="checkbox"/>	<input type="checkbox"/>
Are you sexually active?	<input type="checkbox"/>	<input type="checkbox"/>
Has anyone forced you to something sexual against your will?	<input type="checkbox"/>	<input type="checkbox"/>
Would you like to be tested for STD's now?	<input type="checkbox"/>	<input type="checkbox"/>
For Females:	Yes	No
Do you have any pelvic or lower abdominal pain?	<input type="checkbox"/>	<input type="checkbox"/>
What contraception do you use? _____		
Do you believe that you are pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
When was your last period? _____		
When was the last time you were sexually active? _____		
Have you ever been pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
If so, how many times? _____		
➤ Number of live births? _____		
➤ Number of miscarriages? _____		
➤ Number of terminations? _____		
When was your last pelvic exam/Pap smear? _____		



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Substance Use:		Yes	No		Yes	No
Have you ever tried smoking cigarettes?	<input type="checkbox"/>	<input type="checkbox"/>	If so, when was the last time?	_____		
Do you smoke cigarettes regularly?	<input type="checkbox"/>	<input type="checkbox"/>	If so, how many cigarettes each day?	_____		
At what age did you start? _____			Are you interested in quitting?		<input type="checkbox"/>	<input type="checkbox"/>
Have you ever tried beer, wine or other liquor?	<input type="checkbox"/>	<input type="checkbox"/>	If so, when was the last time?	_____		
Do you drink alcohol regularly?	<input type="checkbox"/>	<input type="checkbox"/>	If so, how often? _____			
Have you ever been drunk?	<input type="checkbox"/>	<input type="checkbox"/>				
Do you use any "street drugs" such as marijuana, ecstasy and others?					<input type="checkbox"/>	<input type="checkbox"/>
If so, Which ones? _____						

REVISIONS TO HEALTH-RELATED HISTORY

Since the Health-Related History was originally completed, the following health-related events have occurred:

Event Number	Health-Related Event	Notes	Date
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Signatures

1. _____ Signature/Title _____ Printed Name _____ Facility _____ Date	4. _____ Signature/Title _____ Printed Name _____ Facility _____ Date
2. _____ Signature/Title _____ Printed Name _____ Facility _____ Date	5. _____ Signature/Title _____ Printed Name _____ Facility _____ Date
3. _____ Signature/Title _____ Printed Name _____ Facility _____ Date	6. _____ Signature/Title _____ Printed Name _____ Facility _____ Date