Pueblo Community Health Center
Your Health. Our Mission.

School-Based Wellness Center
Health History and Prevention Services Form

Student Name:_____ Date of Birth:_____

Confidential:
Please complete the following so that we may update our records. Please complete the following medical history information to the best of your ability. If you have had any of the following illnesses or problems, please write down the age when the illness or problem started.

Allergies……..	Y___N___	Pneumonia……..	Y___N___
Anemia or blood disorders……..	Y___N___	Rheumatic Fever or heart disease……...	Y___N___
Asthma…….	Y___N___	Scoliosis……..	Y___N___
Bladder or kidney infections……...	Y___N___	Seizures……...	Y___N___
Cancer……..	Y___N___	Severe Acne……	Y___N___
Chicken pox…….	Y___N___	Sports Injury or fractures……	Y___N___
Diabetes……...	Y___N___	Thyroid disease……...	Y___N___
Endocrine/gland disease……..	Y___N___	Tuberculosis……	Y___N___
Hepatitis……..	Y___N___	Ulcer or Stomach problems……	Y___N___
Headaches/Migraines……..	Y___N___	Changes in your bowel/bladder……..	Y___N___
Menstrual cramps frequent and/or painful…..	Y___N___	Do you take prescription medications……	Y___N___
Do you smoke……..	Y___N___	If yes what_____	
If yes, how many per day_____		Do you take non-prescription drugs……	Y___N___
Do you chew tobacco……..	Y___N___	If yes what_____	
Do you drink alcohol…….....	Y___N___	Mental illness or depression……	Y___N___
If yes, when and how much_____		Other_____	

Student Signature: _____ Date:_____

Parent Signature: _____ Date:_____

Reviewed by: _____ Date:_____