KU WICHITA PEDIATRICS
The University of Kansas

SCHOOL-BASED HEALTH CARE

USD 262 - Valley Center
STAFF HISTORY FORM

NAME_____ **DOB**_____ **TODAY'S DATE**_____

Why are you here today? _____

LIST YOUR ILLNESSES, HOSPITALIZATIONS, SURGERIES, AND INJURIES:
Date Reason

_____
_____
_____

LIST YOUR CURRENT MEDICATIONS AND SUPPLEMENTS:
Name of Medicine Strength Directions for use

_____
_____
_____

ANY ALLERGIES (Medications, Food, Etc.)

_____
_____

IMMUNIZATION HISTORY:
Last Tetanus (Td or Tdap) _____ Last Influenza _____
Have you received a Pneumonia vaccine? YES NO Have you received a Shingles vaccine? YES NO

FAMILY HISTORY:
Relationship Age Any Health Problems
Father _____
Mother _____
Sibling(s) _____
Children _____

Has any blood relative ever had?:

Cancer	YES NO	High Blood Pressure	YES NO	Convulsions	YES NO
Tuberculosis	YES NO	Diabetes	YES NO	Emotional Problems	YES NO
Heart Trouble	YES NO	Stroke	YES NO	Substance Abuse	YES NO
Gout/Arthritis	YES NO	Bleeding Tendency	YES NO		

SOCIAL HISTORY (Circle One):
Marital Status: SINGLE MARRIED SEPARATED DIVORCED WIDOWED
Sexual Preference: MALE FEMALE BOTH
Have you been sexually active in the last month? YES NO

How many people live in your household? _____ What form of transportation do you use? _____
Employed outside of the home? YES NO What is your job title? _____
Are you or have you ever been exposed to fumes, dusts, or solvents? YES NO

Do you use tobacco (cigarettes, cigars, pipe, chewing tobacco)? YES NO If no, previous use? YES NO
Amount used (previous or current)? _____ Packs per day
Do you use alcoholic beverages? YES NO Amount used? _____ Drinks per week _____
Have you ever used any of the following? MARIJUANA COCAINE HEROIN METHAMPHETAMINE
OTHER IV DRUGS

SOCIAL HISTORY *Continued* (Circle One):

Seatbelts?	ALWAYS ☐	SOMETIMES ☐	NEVER ☐
Sunscreen?	ALWAYS ☐	SOMETIMES ☐	NEVER ☐
Exercise?	ALWAYS ☐	SOMETIMES ☐	NEVER ☐
Regular Balanced Meals?	ALWAYS ☐	SOMETIMES ☐	NEVER ☐

See a dentist regularly? YES ○ NO ○ Last dentist appointment? _____

See an eye doctor regularly? YES ○ NO ○ Last eye exam? _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Recent weight change	YES ○	NO ○	Fast or skipped heartbeat	YES ○	NO ○	Urinating more often	YES ○	NO ○
Skin disease	YES ○	NO ○	Chest pain or heaviness	YES ○	NO ○	Night time urination	YES ○	NO ○
Jaundice (yellow skin)	YES ○	NO ○	Shortness of breath	YES ○	NO ○	Burning/painful urination	YES ○	NO ○
Hives, eczema, rash	YES ○	NO ○	Heart trouble/heart attack	YES ○	NO ○	Blood in urine	YES ○	NO ○
Moles or skin changes	YES ○	NO ○	High blood pressure	YES ○	NO ○	Kidney infection	YES ○	NO ○
Eye problems	YES ○	NO ○	Swelling hands/feet/ankles	YES ○	NO ○	Kidney stones	YES ○	NO ○
Wear glasses	YES ○	NO ○	Heart murmur	YES ○	NO ○	Bladder incontinence	YES ○	NO ○
Double vision	YES ○	NO ○	Blood clots	YES ○	NO ○	Sexually transmitted disease	YES ○	NO ○
Headaches	YES ○	NO ○	Anemia	YES ○	NO ○	Convulsions/seizures	YES ○	NO ○
Nosebleeds	YES ○	NO ○	Peptic ulcer	YES ○	NO ○	Fainting spells	YES ○	NO ○
Sinus trouble	YES ○	NO ○	Vomiting	YES ○	NO ○	Shaking or trembling	YES ○	NO ○
Ear problems	YES ○	NO ○	Gallbladder disease	YES ○	NO ○	Muscle weakness	YES ○	NO ○
Hearing loss	YES ○	NO ○	Liver disease	YES ○	NO ○	Stiff or painful joints	YES ○	NO ○
Dizziness	YES ○	NO ○	Hepatitis	YES ○	NO ○	Hot or cold flashes	YES ○	NO ○
Difficulty swallowing	YES ○	NO ○	Blood in stool	YES ○	NO ○	Difficulty making decisions	YES ○	NO ○
Neck stiffness	YES ○	NO ○	Black stool	YES ○	NO ○	Memory loss	YES ○	NO ○
Thyroid disease	YES ○	NO ○	Change in bowel habits	YES ○	NO ○	Difficulty relaxing	YES ○	NO ○
Swollen glands	YES ○	NO ○	Diarrhea	YES ○	NO ○	Do you lose your temper often	YES ○	NO ○
Coughing	YES ○	NO ○	Heartburn/indigestion	YES ○	NO ○	Are you having sexual problems	YES ○	NO ○
Asthma/wheezing	YES ○	NO ○	Abdominal pain	YES ○	NO ○	Do you feel lonely or depressed	YES ○	NO ○
Problems breathing	YES ○	NO ○	Trouble sleeping	YES ○	NO ○	Have you ever considered suicide	YES ○	NO ○
Lung disease	YES ○	NO ○	Feel tired most of the time	YES ○	NO ○	Panic or anxiety attacks	YES ○	NO ○

Do you consider your health (circle one): EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐

FOR MEN ONLY:

Last testicular exam _____ Last prostate exam _____

FOR WOMEN ONLY:

Age menstrual cycles began _____
How often are periods? Every_____ days
How long do periods last? _____days
How long do periods last? _____days
How long do periods last? _____days
Date of last period _____
Vaginal discharge YES ○ NO ○

Last mammogram (breast exam) _____
Breast lump or nipple discharge YES ○ NO ○

Last pap smear & results _____
Number of pregnancies _____
Number of miscarriages/abortions _____
Have you ever had a DEXA scan? YES ○ NO ○
If so, when was your last one? _____

REVIEW:

Signature _____ Date _____