



YOUTH WITH A MISSION
Las Vegas

Confidential Health History

Name: _____

Date of Birth (Day/Month/Year): _____ Age: _____

Permanent Address: _____

Phone Number: _____

In case of emergency, contact: _____ Relationship: _____

Address: _____

Home Phone Number: _____ Work Phone Number: _____

1. Blood Type: _____ 2. Height (ft./cm): _____ 3. Weight (lbs./kg): _____

4. Rate your health: Very Good Good Average Below Average Other: _____

5. Do you have any objection to using medical services? Yes No
If yes, please explain: _____

6. Have you struggled with any eating disorders (anorexic, bulimic, compulsive)? Yes No
If yes, please describe: _____

7. List all important past surgeries, X-rays, illnesses, injuries, or handicaps and briefly explain: _____

8. Please describe any special dietary needs: _____
Does this limit you in any way? _____

9. Date of last medical examination: _____

10. Do you drink alcoholic beverages? Yes No
If yes, how often? _____ What quantity? _____

11. Do you smoke? Yes No Are you willing to quit? Yes No

12. Are you presently taking any medication? Yes No
If yes, name of drug: _____
For what ailment or condition? _____

13. Do you ever have trouble sleeping? Yes No
If yes, please describe: _____

14. Have you ever had a severe emotional upset, or been diagnosed with a mental illness? Yes No
(i.e. depression or other mental illness)? If yes, please describe: _____

15. Have you ever had suicidal thoughts or attempts? Yes No
If yes, please comment: _____

16. Have you ever used drugs for anything other than medical purposes or abused prescription medication? Yes No
If yes, when? _____ Name of drug(s)? _____ For how long? _____

17. Are you pregnant? Yes No If yes, when is your due date? _____
 Have you been pregnant before? Yes No

18. Have you been tested for HIV? Yes No Did you test positive or negative? _____

19. Have you ever had or do you have any of the following?

If yes, please describe on a separate sheet of paper:

Allergy to:

Food - <i>specify</i>	Yes	No	Hepatitis	Yes	No	What type? _____
Penicillin	Yes	No	Low Blood Pressure	Yes	No	
Selfonamides	Yes	No	High Blood Pressure	Yes	No	
Serum	Yes	No	Insomnia	Yes	No	
Other - <i>specify</i>	Yes	No	Intestinal Trouble	Yes	No	
Anemia	Yes	No	Jaundice	Yes	No	
Asthma	Yes	No	Kidney Disease	Yes	No	
Back Problems	Yes	No	Migraines	Yes	No	
Broken Bones	Yes	No	Nervous Disorders	Yes	No	
Diabetes	Yes	No	Paralysis	Yes	No	
Dislocation of joints	Yes	No	Recurring Diarrhea	Yes	No	
Ear trouble	Yes	No	Rheumatism/Arthritis	Yes	No	
Epilepsy	Yes	No	Shortness of Breath	Yes	No	
Eye Trouble	Yes	No	Skin Condition	Yes	No	
Fainting Spells	Yes	No	Stomach/duodenal ulcer	Yes	No	
Gall Bladder Problems	Yes	No	Tumor/Cancer	Yes	No	
Hay Fever	Yes	No	Venereal Disease	Yes	No	
Head Injury	Yes	No		<i>Which one?</i> _____		
Heart Condition	Yes	No	Weakness	Yes	No	

20. Have you ever had any of the following communicable diseases?

Chicken Pox	Yes	No
Measles (Rubella)	Yes	No
Measles (Rubeola)	Yes	No
Mumps	Yes	No
Pertussis	Yes	No
Scarlet Fever	Yes	No
Tuberculosis	Yes	No

Other, please specify: _____

21. Immunization Record

			Date (Month/Year)
BCG	Yes	No	_____
Cholera	Yes	No	_____
DPT.Td (series of 3)	Yes	No	_____
Measles (Rubeola)	Yes	No	_____
Measles (Rubella)	Yes	No	_____
Polio (series of 3)	Yes	No	_____
Polio	Yes	No	_____
Smallpox	Yes	No	_____
Td Booster	Yes	No	_____
Tetanus Booster	Yes	No	_____
Typhoid (series of 3)	Yes	No	_____
Yellow Fever	Yes	No	_____

22. Have any of your relatives ever had any of the following?

			Relationship
Arthritis	Yes	No	_____
Asthma, Hay Fever	Yes	No	_____
Diabetes	Yes	No	_____
Epilepsy	Yes	No	_____
Heart Disease	Yes	No	_____
Kidney Disease	Yes	No	_____
Stomach Disease	Yes	No	_____
Tuberculosis	Yes	No	_____