FLORIDA DEPARTMENT OF JUVENILE JUSTICE

HRH

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?
☐	☐	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.

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D. PERSONAL HISTORY (Check all that apply)			
	Self Only		Self Only
Antibiotics- Dental Work (due to heart defects)	☐	Recurrent Diarrhea	☐
Chicken Pox	☐	Rheumatic Fever	☐
Ear, Nose and Throat Trouble	☐	Scoliosis	☐
Eye Trouble	☐	Sexually Transmitted Diseases (STDs)	☐
Head Injury with unconsciousness	☐	Skin Diseases (acne, eczema, psoriasis)	☐
Hospitalizations/Surgery (specify)	☐	Strep Throat	☐
Mononucleosis(Date)	☐	TMJ (jaw problems)	☐
Pregnancy	☐	Transfusions (Date)	☐
Recurrent Bladder Infections	☐	Varicose Veins	☐

D. PERSONAL AND FAMILY HISTORY (Check all that apply)							
	Self Only	Immediate Family	Grand parent		Self Only	Immediate Family	Grand parent
ADHD	☐	☐	☐	Epilepsy, Seizures	☐	☐	☐
Alcohol/Drug Dependency	☐	☐	☐	Gallbladder Trouble	☐	☐	☐
Allergy, Hay Fever	☐	☐	☐	Heart Murmur/Disease	☐	☐	☐
Anemia/blood disease/sickle cell	☐	☐	☐	High Blood Pressure	☐	☐	☐
Anorexia Nervosa	☐	☐	☐	Kidney Disease/Infections	☐	☐	☐
Anxiety	☐	☐	☐	Liver Disease/Jaundice	☐	☐	☐
Arthritis	☐	☐	☐	Malaria	☐	☐	☐
Asthma	☐	☐	☐	Migraines	☐	☐	☐
Back Problems	☐	☐	☐	Obesity	☐	☐	☐
Blood Clot/Phlebitis	☐	☐	☐	Other Psychological Problems	☐	☐	☐
Bulimia	☐	☐	☐	Peptic Ulcer Disease	☐	☐	☐
Cancer, Cyst, Tumor	☐	☐	☐	Suicidal Ideation	☐	☐	☐
Depression	☐	☐	☐	Thyroid Disease	☐	☐	☐
Diabetes/Hypoglycemia	☐	☐	☐	Tuberculosis	☐	☐	☐

Family History:

Father:	☐ Living	☐ Deceased	Age at Death:	Cause:
Mother:	☐ Living	☐ Deceased	Age at Death:	Cause:

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

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

Reproductive Health:

For Females:	Yes	No
Do you have any pelvic or lower abdominal pain?	☐	☐
What contraception do you use? _____		
Do you believe that you are pregnant?	☐	☐
When was your last period? _____		
When was the last time you were sexually active? _____		
Have you ever been pregnant?	☐	☐
If so, how many times? _____		
➢ Number of live births? _____		
➢ Number of miscarriages? _____		
➢ Number of terminations? _____		
When was your last pelvic exam/Pap smear? _____		

Substance Use:	Yes	No		Yes	No
Have you ever tried smoking cigarettes?	☐	☐	If so, when was the last time? _____		
Do you smoke cigarettes regularly?	☐	☐	If so, how many cigarettes each day? _____		
At what age did you start? _____			Are you interested in quitting?	☐	☐
Have you ever tried beer, wine or other liquor?	☐	☐	If so, when was the last time? _____		
Do you drink alcohol regularly?	☐	☐	If so, how often? _____		
Have you ever been drunk?	☐	☐			
Do you use any "street drugs" such as marijuana, ecstasy and others?				☐	☐
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	2. _____ Signature/Title _____ Printed Name _____ Facility _____ Date
3. _____ Signature/Title _____ Printed Name _____ Facility _____ Date	4. _____ Signature/Title _____ Printed Name _____ Facility _____ Date
5. _____ Signature/Title _____ Printed Name _____ Facility _____ Date	6. _____ Signature/Title _____ Printed Name _____ Facility _____ Date

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