FLORIDA DEPARTMENT OF JUVENILE JUSTICE

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		☐	Mononucleosis (date) _____		☐
Antibiotics - Dental Work (due to heart defects)		☐	Pregnancy		☐
Back Problems		☐	Recurrent Bladder Infections		☐
Blood Clot/Phlebitis		☐	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		☐
			TMJ (jaw problems)		☐
			Transfusions (date) _____		☐
Hypoglycemia		☐	Varicose Veins		☐
Malaria (date) _____		☐	Other Chronic Conditions		☐

D. PERSONAL AND FAMILY HISTORY
(Check all that apply)

	Family	Self Only		Family	Self Only
Alcohol/Drug Dependency	☐	☐	Heart Murmur/Disease	☐	☐
Allergy, Hay Fever	☐	☐	High Blood Pressure	☐	☐
Anemia/Blood disease/Sickle Cell Anemia/ Trait	☐	☐	Kidney Disease/Infections	☐	☐
Anorexia Nervosa	☐	☐	Liver Disease/Jaundice	☐	☐
Anxiety	☐	☐	Migraines	☐	☐
Arthritis	☐	☐	Obesity	☐	☐
Asthma	☐	☐	Peptic Ulcer Disease	☐	☐
Bulimia	☐	☐	Suicidal Ideation	☐	☐
Cancer, Cyst, Tumor	☐	☐	Other Psychological Problems	☐	☐
Diabetes	☐	☐	Thyroid Disease	☐	☐
Depression	☐	☐	Tuberculosis	☐	☐
Epilepsy, Seizures	☐	☐	Other	☐	☐
Gallbladder Trouble	☐	☐			

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	

*** 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?	☐	☐
Are you sexually active?	☐	☐
Has anyone forced you to something sexual against your will?	☐	☐
Would you like to be tested for STD's now?	☐	☐
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	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