HEALTHY PARTNERSHIPS

A DIVISION OF CAMINAR

FOR HEALTHIER INDIVIDUALS, FAMILIES & COMMUNITIES

A division of Caminar

YOUTH HEALTH QUESTIONNAIRE

Date: _____
Name: _____ Date of Birth:_____
Social Security #:_____

This brief questionnaire is about your health. It will assist us in determining your ability to participate in our program. This information is confidential.

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1. Do you have any serious health problems or illnesses (such as tuberculosis or active pneumonia) that may be contagious to others around you? If **yes**, please give details.
□-Yes □-No Date of Health Problem/Illness: _____
_____

2. Have you ever had a stroke? If **yes**, please give details.
□-Yes □-No Date Stroke Occurred: _____
_____

3. Have you ever had a head injury that resulted in a period of loss of consciousness? If **yes**, please give details.
□-Yes □-No Date of Head Injury: _____
_____

4. Have you ever had any form of seizures, delirium tremens, or convulsions? If **yes**, please give details.
□-Yes □-No Date of Incident(s): _____
_____

5. Have you experienced or suffered any chest pain? If **yes**, please give details.
□-Yes □-No Date Experienced: _____
_____

6. Have you ever had a heart attack or any problem associated with the heart? If **yes**, please give details.
□-Yes □-No Date of Heart Condition: _____
_____

7. Do you take any medications for a heart condition? If **yes**, please give details.
□-Yes □-No
_____

8. Have you ever had blood clots in the leg or elsewhere that requires medical attention? If **yes**, please give details.
□-Yes □-No Date of Blood Clots: _____
_____

9. Have you ever had high-blood pressure or hypertension? If **yes**, please give details.

□-Yes □-No Date Diagnosed: _____

_____

10. Do you have a history of cancer? If **yes**, please give details.
□-Yes □-No Date Diagnosed: _____

_____

11. Do you have a history of any other illness that may require frequent medical attention? If **yes**, please give details.
□-Yes □-No

_____

12. Do you have any allergies to medications, foods, animals, chemicals, or any other substance? If **yes,** please give details.
□-Yes □-No

_____

13. Have you ever had an ulcer, gallstones, internal bleeding or any type of bowel or colon inflammation? If **yes**, please give details.
□-Yes □-No Date of Issue: _____

_____

14. Have you ever been diagnosed with diabetes? If **yes**, please give details, including insulin, oral medication, or special diet.
□-Yes □-No Date Diagnosed: _____

_____

15. Have you ever been diagnosed with any type of hepatitis or other liver illness? If **yes**, please give details.
□-Yes □-No Date Diagnosed: _____

_____

16. Have you ever been told that you have problems with your thyroid gland? Have you ever been treated for, or told you need to be treated for, any type of glandular disease? If **yes**, please give details.
□-Yes □-No Date of Issue: _____

_____

17. Do you currently have any lung diseases such as asthma, emphysema, or chronic bronchitis? If **yes**, please give details.
□-Yes □-No Date Diagnosed: _____

_____

18. Have you ever had kidney stones or kidneys infections? Have you had any problems, or been told that you have problems, with your kidneys or bladder? If **yes**, please give details.
□-Yes □-No Date of Issue: _____

_____

19. Do you have any of the following: arthritis, back problems, bone injuries, muscle injuries, or joint injuries? If **yes**, please give details, including any ongoing pain or disabilities.
□-Yes □-No Date of Issue: _____
_____

20. Please describe any surgeries or hospitalizations due to illness or injury that you have had.
Date(s) of Surgeries/Hospitalizations:_____
_____
_____

21. When was the last time you saw a physician? What was the purpose of the visit?
Date of Visit:_____
_____

22. Do you take any prescription medications including psychiatric medication? □-Yes □-No If **yes**, please list type(s) and dosage(s). _____
_____

23. Do you take any over the counter pain medication, such as: Aspirin, Tylenol, or Ibuprofen? □-Yes □-No
If **yes**, list the medication(s) and how often you take it.
_____

24. Do you take over the counter digestive medications such as Tums or Maalox? □-Yes □-No
If **yes**, list the medication(s) and how often you take it.
_____

25. Do you wear or need to wear glasses, contact lenses, or hearing aids? □-Yes □-No If **yes**, please give details.
_____

26. When was your last dental exam? Date of Exam:_____

27. Are you in need of dental care? If **yes**, give details. □-Yes □-No
_____

28. Do you wear or need to wear dentures or other dental appliances that may require dental care? □-Yes □-No
If **yes**, please give details.
_____

29. Are you pregnant? □-Yes □-No Due Date: _____

30. Who is your primary care physician/medical doctor?

_____
Physician's Name Address Phone Number Hours of Operation

31. In the past seven days have you used any drugs, including alcohol? □-Yes □-No If **yes**, please list:

Type of Drug	Route of Administration

33. Do you suffer from any illnesses not mentioned previously? □-Yes □-No
If **yes**, please explain:

_____

_____

34. Date of last TB _____ Results _____

35. Date of last physical examination: _____

Client Name: _____ Client Signature: _____ Date: _____

Reviewed by:_____ Signature: _____ Date:_____