THE HEALTH & WELLNESS CENTER AT CENTENNIAL HIGH SCHOOL

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SUMMER 2017 - STUDENT MEDICAL HISTORY

PLEASE PRINT

Student Last Name:	First Name:	Date of Birth (mm/dd/yy) ____/_____/____
Primary Care Dr./Practice	Phone:	Pharmacy:
Last complete/sports/ physical date:		

MEDICATIONS

Is the student currently taking medications: Yes No *If Yes, please fill out this table:*

MEDICATION NAME/DOSAGE/WHEN TAKEN	REASON FOR MEDICATION

ALLERGIES

Does the student have any allergies: Yes No *If Yes, please fill out this table:*

Medication allergies: ☐ Yes ☐ No *If Yes, please list any medication and allergic reaction*:	
Medication	*Reaction*
Medication	*Reaction*
Other allergies: ☐ Yes ☐ No *If Yes, please describe:*	

PAST MEDICAL HISTORY

(circle any conditions that the student currently has, or has had in the past, and please describe below)

Autism	Eating disorders	Migraine headaches	Skin problems
Anemia	Fainting with exercise	Missing an organ	Stomach/intestinal problems
Asthma	Head injury/concussion	Mono (within past month)	Stroke
Cancer/Type_____	Heart problems	Obesity	Surgeries/Type_____
Chest pain with exercise	High blood pressure	Pregnancy	Thyroid problems
Diabetes	Kidney problems	Seizures	
Drug or alcohol addiction	Liver problems	Sickle cell disease/trait	

Other concerns not listed: ☐ Yes ☐ No If Yes, explain _____

Explain any conditions circled above _____

CONTINUED – SEE NEXT PAGE

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MENTAL HEALTH HISTORY

Student has a history of mental health diagnosis: Yes No *If Yes, please fill out this table:*

Diagnosis:	Name of counselor:	Psychiatrist:
Other important mental health history:		

PAST HOSPITALIZATIONS

Has the student ever had to stay in the hospital: Yes No *If Yes, Please explain:*

_____

_____

FAMILY HEALTH HISTORY (circle any conditions affecting immediate family members and describe below)

Anemia	Depression/Anxiety	Liver disease	Seizures
Bipolar disorder	Diabetes	Lung disease	Stroke
Blood Clotting disorders	Drug/alcohol addiction	Migraine headaches	Sudden death Suicide
Breast cancer	Heart Disease Heart attack under 50	Obesity	Thyroid problems
Cancer; Type _____	Kidney disease	Schizophrenia	Other: _____

Describe any circled responses: _____

_____

_____

_____

I understand that if there are important changes to the medical history of the student or the medical history of the student's family that Health and Wellness Center will be notified directly by calling 970-488-4950 or notifying the provider in person. This is to ensure that the student is provided with the highest quality health care possible.

_____ _____ _____

PRINTED Name of Parent/Guardian (or Student if 18+) **Signature of Parent/Guardian (or Student if 18+)** **Date**