Clarity Healthcare and Preferred Family Healthcare Spartan Health Clinic Health History Form

MOBERLY SCHOOL DISTRICT

School:

- ❑ Moberly High School
- ❑ Moberly Middle School
- ❑ MATC
- ❑ Gratz Brown
- ❑ South PArk
- ❑ North Park
- ❑ ECC
- ❑ Alt School

Student Name: _____ **Age** _____

DOB: _____ **Gender: M** ____ **F**____ **Transgender** ____

Parent/Guardian name:_____

Primary Care Provider:_____

Preferred Pharmacy:_____

ALLERGIES ☐ NO ALLERGIES

ALLERGY	REACTION

MEDICATIONS ☐ NO MEDICATIONS

MEDICATION (DOSE/FREQUENCY)	REASON	STARTED WHEN

IF INDICATED, do you consent for your child to receive **ANY** of the below medications/injections while at school:

MEDICATION	REASON FOR USE	CONSENT FOR USE
Zofran	**Nausea/Vomiting**	**Y N**
Ketorolac	**Migraine**	**Y N**
Kenalog/Depo-Medrol/Dexamethasone	**Poison Ivy/Hay Fever**	**Y N**
Rocephin	**Infections**	**Y N**
Albuterol/DuoNeb	**Asthma/Bronchospasm**	**Y N**

OTHER PROVIDERS/SPECIALIST

SPECIALIST	NAME	LAST VISIT

Has your child ever been hospitalized? ____Yes ____No

If yes, give the age at the time of hospitalization and describe the problem.

PROBLEM	AGE

HISTORY FOR STUDENT/FAMILY	STUDENT	FAMILY	FM Member
Allergies: Seasonal/Hay fever	Y N	Y N	
Life Threatening Allergy to: _____ **EpiPen prescribed*	Y N Y N		
ADD/ADHD/Behavioral Problems	Y N	Y N	
Depression	Y N	Y N	
Suicidal	Y N	Y N	
Emotional/Psychological Problems	Y N	Y N	
Sexual or Physical Abuse	Y N	Y N	
Developmental Problems _____	Y N	Y N	
Learning problems _____	Y N	Y N	
Problems with Vision Wears **Glasses* **Contacts*	Y N Y N Y N	Y N	
Eye Infections	Y N	Y N	
Hearing Problems	Y N	Y N	
Chronic Ear Infections	Y N	Y N	
Chronic Throat Infections	Y N	Y N	
Toothaches/Dental Problems	Y N	Y N	
Frequent Headaches **Migraines* **Head Injury/ Concussion*	Y N Y N Y N	Y N	
Seizure Disorder/Epilepsy/Tics	Y N	Y N	
Sleep Problems	Y N	Y N	
Immune Deficiency Disorders	Y N	Y N	
Chest Pain/Tightness	Y N	Y N	
Asthma **no medications* **daily medications/rescue inhalers*	Y N Y N Y N	Y N	
Pneumonia	Y N	Y N	
Bronchitis	Y N	Y N	

HISTORY FOR STUDENT/FAMILY	STUDENT	FAMILY	FM Member
Heart Disease – type _____	Y N	Y N	
Murmur/Palpitations	Y N	Y N	
Blood Pressure Problems *(High/Low)*	Y N	Y N	
Frequent Stomach Aches	Y N	Y N	
Heartburn/Acid Reflux/Ulcer	Y N	Y N	
Abdominal Cramping	Y N	Y N	
Chronic Diarrhea or Constipation	Y N	Y N	
Hernia	Y N	Y N	
Eating Problems	Y N	Y N	
Weight Problems	Y N	Y N	
Arthritis/Joint Pain/Gout	Y N	Y N	
Kidney Disease – type _____	Y N	Y N	
Frequent Urinary Tract Infections	Y N	Y N	
Anemia or Other Blood Problems	Y N	Y N	
Sickle Cell Disease	Y N	Y N	
Diabetes **Type 1* **Type 2*	Y N Y N Y N	Y N Y N Y N	
Hypothyroidism/Thyroid Disease	Y N	Y N	
Eczema/Chronic Skin Condition	Y N	Y N	
Chickenpox	Y N	Y N	
MRSA	Y N	Y N	
Cancer – type _____	Y N	Y N	
Tobacco Use **How Much_____* **How Long_____* **Type:_____*	Y N	Y N	
Alcohol/Drug Abuse **How Much_____* **How Long_____* **Type:_____*	Y N	Y N	