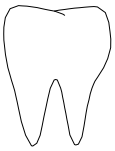
PERSONAL HEALTH CARE

Taking care of your personal health and obtaining the necessary health information and/or services is an important life-long task. You should also know your own health history (any illnesses, immunizations, allergies, etc.). Keeping yourself healthy involves not only getting proper medical treatment when you're sick, but also preventing health problems as well.

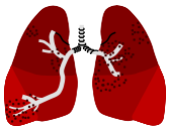
Consider the following examples:



Niklaus has a cavity and is supposed to make an appointment with the dentist. However, he does not follow through. What long-term and short-term consequences do you think Niklaus might suffer by not scheduling a dentist's appointment?

Short Term:

Long Term:



Leah is a cheerleader at her high school. There is a history of asthma in her family. Recently, she has had trouble catching her breath, oftentimes during her cheerleading practice. However, her breathing always seems to improve after a little while. Leah is afraid that if she tells someone about her problem, she won't be able to be a cheerleader anymore. She thinks that her difficulty breathing might just go away by itself. Do you think Leah is right? What would you do?

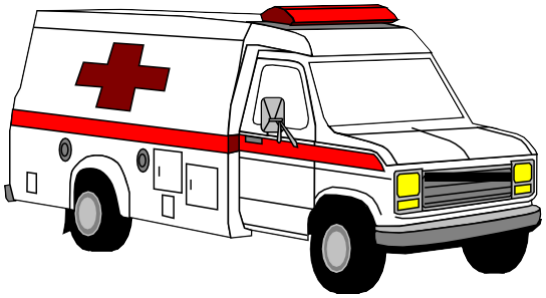
Take some time and answer the questions below with a foster parent, staff, or social worker to evaluate your personal health care needs. Mark those questions that need some follow-up, and plan with your foster parent, program staff, and/or social worker how you will get the information or services you need.

	YES	NO
Do you have a Medical Passport?	☐	☐
Do you have any questions about the information in the passport?	☐	☐
Has anyone gone over the information in the Passport with you?	☐	☐
Do you know when your last medical checkup was?	☐	☐
Do you know when your last dental checkup was?	☐	☐
Is your general health good?	☐	☐
Do you have a family history of any particular disease?	☐	☐
Do you have any allergies?	☐	☐
Are you taking medication or getting any regular treatments?	☐	☐
Did either the doctor or dentist suggest you make another appointment to have a problem followed?	☐	☐
Do health problems often interfere with your daily activities (keep you out of work, school, sports, etc.)?	☐	☐
Do you have a lot accidents or injuries?	☐	☐
Do you think you have a problem with alcohol or drugs?	☐	☐
Do the people you live with or your friends think you have a problem with alcohol or drugs?	☐	☐
Do you use birth control?	☐	☐
Do you have a doctor that you feel comfortable seeing?	☐	☐
Is there any health problem you'd like to have checked or a question you'd like to ask if the service was free and confidential (just between you and the doctor)?	☐	☐
Do you see a counselor or therapist?	☐	☐
If not, would you like to have someone with whom you could discuss your feelings and concerns?	☐	☐

My Personal Health Care Needs:

I need to follow up on...		*...by getting information or services from...*
	➔	
	➔	
	➔	
	➔	
	➔	

It is important to keep track of all your medical records. Be sure to put them in a safe and easily accessible place -- maybe your document portfolio. Not even doctors are able to read your mind. They need information to treat you properly. In a medical emergency or during a regularly scheduled doctor's visit, the more information you can provide to the medical care staff, the better they will be able to care for you.



Jan knew Jack was driving too fast that day but never would have thought there might really be a car crash. Nevertheless, here they were in an ambulance on the way to the emergency room. The EMTs (Emergency Medical Technicians) asked Jan if she was allergic to a list of things, and she had no idea whether she was or not.

Why did the EMTs ask Jan that question?_____

_____

_____

What information could Jan give them that would be helpful?_____

_____

_____

FAMILY MEDICAL HISTORY

Family medical history is very important. Your Medical Passport should include a fair amount of this information, so be sure to have a personal copy for your own records.

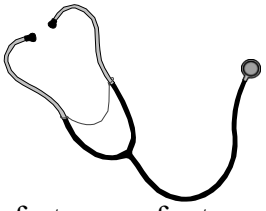
If you do not have much family health history information available to you, you should ask your social worker, foster parent, or staff to help you obtain the health history.

Family History

Have any of your blood relatives (brothers, sisters, parents, grandparents) ever had any of the following medical problems?

- ☐ Diabetes
- ☐ TB skin test (positive results)
- ☐ High blood pressure
- ☐ Anemia
- ☐ Heart attack before the age of 60
- ☐ Kidney problem
- ☐ Mental retardation
- ☐ Learning problem
- ☐ Arthritis
- ☐ Other: _____
- ☐ Migraine headaches
- ☐ Alcohol or drug problem
- ☐ Epilepsy, convulsions, or seizures
- ☐ Psychiatric problems
- ☐ Stroke
- ☐ Birth defects
- ☐ Death at a young age
- ☐ Stomach or intestinal problems
- ☐ Asthma
- ☐ Cancer (Type:_____)

Let's look at Bob's example:



Bob is 17 years old and has been in foster care for two and a half years. Recently, he has been suffering really bad headaches which aspirin doesn't seem to help. He and his foster mother are at the doctor's office now, where Bob is trying to fill out the health questionnaire the nurse has given him. Bob is having a hard time answering some of the medical history questions, especially those about his sisters, brothers, parents, and grandparents.

What should Bob do? _____

_____

_____

Who could help him? _____

_____

_____

What should he tell the doctor or nurse? _____

_____

_____

What can he do for "next time" to be better prepared for this kind of thing? _____

_____

_____

What section in the Medical Passport offers some information that will help? _____

_____

_____

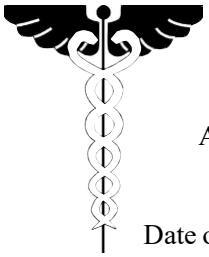
Do you need to obtain more information? If so, use the chart below to plan how you will get additional information about your medical history:

I need more information about...		Strategy
	⇨	
	⇨	
	⇨	
	⇨	
	⇨	

ACTIVITY

Here is a sample Health Questionnaire, similar to one that you might be asked to fill out when visit a new doctor or clinic. Answer the questions that you know and put a question mark (?) next to those you don't know. Then review this questionnaire with your social worker and foster parent or program staff to help you find the missing information.

Health Questionnaire



Name :

Address :

Date of Birth :

What questions or health problems would you like to see the doctor about today? _____

_____

_____

Are you taking any medication? ☐ Yes ☐ No

If Yes, what medicines do you take? _____

_____

_____

Medical History

Where were you born? _____ Hospital

_____ City

How much did you weigh at birth? ☐ lbs. and ☐ oz.

Did your mother have any problems during her pregnancy? If so, describe._____

_____

Did she take any medication?_____

Were there any complications with the birth?_____

Have you ever been admitted to the hospital? ☐Yes ☐No

If yes, please list the dates, hospitals, and reasons for hospitalizations: _____

_____

Have you ever had an allergic reaction (to medicine, food, a bee sting, etc.)? ☐Yes ☐No

If yes, list the substance to which you are allergic: _____

_____

Have you ever had surgery (operations)? ☐Yes ☐No

If yes, please describe: _____

_____

Have you ever had any broken bones or any serious injuries? ☐Yes ☐No

If yes, please describe: _____

_____

Check any of the following illnesses and health problems that you have had or presently have:

- ☐ Anemia
- ☐ Asthma
- ☐ Hay fever
- ☐ Chicken Pox
- ☐ Measles
- ☐ Heart murmur
- ☐ Pneumonia
- ☐ Illness (other than colds, flu, etc.)
- ☐ Stomach/intestinal problems
- ☐ Kidney problem
- ☐ Blood clots or vein problems
- ☐ Hepatitis, jaundice
- ☐ Urinary tract infection
- ☐ Vaginal infection
- ☐ Short or tall for age
- ☐ Overweight
- ☐ Underweight
- ☐ Mononucleosis
- ☐ +TB Test (positive results)
- ☐ High blood pressure
- ☐ Migraine headache
- ☐ Seizures (convulsion, epilepsy)
- ☐ Thyroid problem
- ☐ Concussion
- ☐ Cancer
- ☐ Back/joint pain
- ☐ Pelvic infection
- ☐ Uterus or ovary problem

- ☐ Pregnancy
- ☐ Miscarriage or abortion
- ☐ Venereal disease (VD)
- ☐ Trouble seeing from a distance (near-sightedness)
- ☐ Trouble seeing things close up (far-sightedness)
- ☐ Wear glasses / contact lenses
- ☐ Frequent headaches
- ☐ Frequent tiredness
- ☐ Can't get to sleep easily / insomnia
- ☐ Sleep too much
- ☐ Cold or heat intolerance
- ☐ Dizziness
- ☐ Fainting or passing out
- ☐ Skin problem
- ☐ Severe acne
- ☐ Difficulty hearing
- ☐ Earache
- ☐ Wheezing
- ☐ Cough
- ☐ Heart skips a beat / palpitations
- ☐ Heart races
- ☐ Stomach pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Ringing in ears
- ☐ Sore that doesn't heal or change in wart or mole
- ☐ Blurred vision
- ☐ Constipation
- ☐ Nosebleeds
- ☐ Gum or mouth pain
- ☐ Recent toothache
- ☐ Breast lump
- ☐ Shortness of breath
- ☐ Difficulty with bowel movements
- ☐ Infrequent bowel movements
- ☐ Diarrhea
- ☐ Blood in stool
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Pain with urination
- ☐ Bed wetting
- ☐ Bleed or bruise easily
- ☐ Excessive thirst

List any other illnesses or health problems below:

_____

_____

_____

Females Only: Visit to the gynecologist

Your age when you first got your period _

Cycle length (How long does your period usually last?) _

Irregular (Does the time of your period change from month to month? Yes ☐ No ☐

On what date did your last period start? _

Cramps Yes ☐ No ☐

Excess bleeding with period Yes ☐ No ☐

Vaginal discharge Yes ☐ No ☐

Have had a pelvic (internal) exam before? Yes ☐ No ☐

Date of last pelvic exam _

History of past pregnancy: Have you ever been pregnant? Have you had a miscarriage or abortion? (List responses and dates below.)

_____

Males and Females

Are you sexually active? ☐Yes ☐No

Check all methods of birth control you use:

- ☐ Condoms (rubbers)
- ☐ Birth control pills
- ☐ Diaphragm and spermicidal jelly
- ☐ Contraceptive foam or suppositories
- ☐ Sponge
- ☐ IUD
- ☐ Withdrawal
- ☐ Rhythm
- ☐ Norplant
- ☐ Depo Provera

Substance Use

Do you smoke cigarettes? ☐Yes ☐No

If yes, how many cigarettes do you smoke a day? _____

How many years have you been smoking? _____

Have you ever tried to stop? ☐Yes ☐No

Do you drink alcohol? ☐Yes ☐No

If yes, what kind of alcohol do you usually drink?

_____

How often do you drink? _____

Why do you usually drink?

_____

How much do you usually drink on those days that you do drink? _____ Do you ever drink by yourself? ☐Yes ☐No

Do any of your friends use alcohol? ☐Yes ☐No

Do you use drugs? ☐Yes ☐No

Have you used any of the following drugs in the past month?

Marijuana	☐Yes ☐No	Cocaine	☐Yes ☐No	
Acid	☐Yes ☐No			
Speed	☐Yes ☐No			

Others (please list)_____

Do you use any needle drugs? ☐Yes ☐No

If yes, which types? _____

_____ Are you worried about your drug or alcohol use?

_____

☐Yes ☐No

If yes, please describe.

Is anyone else worried about your drug or alcohol use? ☐Yes ☐No

Would you like to talk to someone about your use of substances? ☐Yes ☐No