Health Review

How many servings do you each **WEEK** of:

Please circle the best answer

Red Meat	0	1	2	3	4	5	6	7	8	9	10	11	12	per WEEK
Chicken	0	1	2	3	4	5	6	7	8	9	10	11	12	per WEEK
Fish	0	1	2	3	4	5	6	7	8	9	10	11	12	per WEEK
Chips	0	1	2	3	4	5	6	7	8	9	10	11	12	per WEEK
Ice cream	0	1	2	3	4	5	6	7	8	9	10	11	12	per WEEK
Frozen yogurt	0	1	2	3	4	5	6	7	8	9	10	11	12	per WEEK
Yogurt	0	1	2	3	4	5	6	7	8	9	10	11	12	per WEEK
Cheese	0	1	2	3	4	5	6	7	8	9	10	11	12	per WEEK
Restaurant meals	0	1	2	3	4	5	6	7	8	9	10	11	12	per WEEK

How many servings do you each **DAY** of:

Milk	0	1	2	3	4	5	6	per DAY
Type of milk		Skim	1.00%	2.00%	Whole			
Fruits	0	1	2	3	4	5	6	per DAY
Vegetables	0	1	2	3	4	5	6	per DAY
Cans/glasses of soda	0	1	2	3	4	5	6	per DAY
Type of soda		Regular	Diet					
Sweets	0	1	2	3	4	5	6	per DAY

1. Do you wear a seatbelt in the car?
   Yes _____ No _____
2. Do any of your teachers have tuberculosis, or an unexplained chronic cough?
   Yes _____ No _____
3. Have you or your parents traveled out of the country in the past year?
   Yes _____ No _____
   If so, where? _____
4. Have you lived with or spent time with anyone who possibly or definitely had tuberculosis, or had a positive skin test for tuberculosis?
   Yes _____ No _____
5. Did you, your parent, or anyone else living in your household come to the United States from another country?
   Yes _____ No _____
   If so, from which country? _____

6. Have you lived with or spent time with adults who:
    - Were homeless, either living on the street or in a shelter?
      Yes _____ No _____
    - Have AIDS or are HIV-infected?
      Yes _____ No _____
    - Use intravenous drugs or other street drugs?
      Yes _____ No _____
    - Lived in a correctional facility (prison), nursing home or mental institution?
      Yes _____ No _____

Please check-off any problems you have had in the past MONTH:

☐	Fever	☐	Constipation
☐	Excessive fatigue	☐	Indigestion/heartburn
☐	Significant weight gain or weight loss	☐	Abdominal pain
☐	New or changing moles	☐	Rectal bleeding
☐	Persistent rash	☐	Black stools
☐	Blurred vision	☐	Burning with urination
☐	Double vision	☐	Leaking urine
☐	Many new floaters	☐	Hernia
☐	Eye pain	☐	Bedwetting
☐	Change in your hearing	☐	Difficulty with focus/attention
☐	Ringing in your ears	☐	Hyperactive
☐	Pain in your ears	☐	Hot or cold when others are not
☐	Dizziness	☐	Back pain
☐	Nasal drainage or sinus pressure	☐	Joint pains
☐	Hoarseness or persistent throat pain	☐	Recent injury
☐	Shortness of breath	☐	Headaches
☐	Wheezing	☐	Numbness or tingling
☐	Cough lasting more than 10 days	☐	Trouble with your balance
☐	Chest pain lasting more than seconds	☐	Feeling blue/sad
☐	Swelling in your legs/feet	☐	Crying for no reason
☐	Cramps in your legs when walking	☐	Feeling nervous about things
☐	Food or pills sticking when you swallow	☐	Worrying about things too much
☐	Vomiting	☐	Irritable, snap at other people
☐	Diarrhea	☐	Trouble sleeping