Student Health History

Student's Name: _____ **Date of Birth:** _____

Pediatrician _____ **Pediatrician's Phone #:** _____ **Last Physical:**_____

Patient's Medical History

ADD/ADHD	Yes	No	Heart Disease	Yes	No
Asthma	Yes	No	Kidney/Renal Disease	Yes	No
Bladder/Urinary Problems	Yes	No	Nosebleeds	Yes	No
Blood Disorder	Yes	No	Pneumonia	Yes	No
Bowel Problems/Constipation	Yes	No	Premature Birth	Yes	No
Cancer/Leukemia	Yes	No	Spine Disorders	Yes	No
Depression/Anxiety	Yes	No	Seizures	Yes	No
Diabetes Mellitus	Yes	No	Sickle Cell	Yes	No
Earaches/Ear Infections	Yes	No	Stomach Aches	Yes	No
Eczema	Yes	No	Wears Glasses or Contacts	Yes	No
Frequent Infections	Yes	No	Wears Hearing Aid	Yes	No
Headaches	Yes	No	Weight Issues	Yes	No

Other: _____

Current Medications:

Does your child take any medications, vitamins, supplements, or natural remedies? Yes No

If yes, please list: _____

_____

Allergies:

Does your child have allergies? Yes (if yes, please list allergies below) No

Food Allergies: _____

Medication Allergies: _____

Animal or insect Allergies: _____

Do allergies Require Epi Pen? Yes No

Asthma Information:

Does your child have an inhaler? Yes No If yes, type of preventive inhaler: _____

Will your child bring inhaler to school? Yes No If yes, type of emergency inhaler: _____

Does child use a nebulizer at home? Yes No

Surgeries/Hospitalizations:

Has your child stayed overnight in the hospital? Yes No Number of visits to the Emergency last year _____

Has your child had a serious injury? Yes No If yes, list: _____

Has your child had surgery? Yes No If yes, list: _____

Family History (maternal and paternal grandparents, parents, siblings)

Have any Blood Relatives of your child had the following problems? (Please check all that apply.)

☐ Anemia	☐ AIDS	☐ High Blood Pressure	☐ Sickle Cell
☐ Diabetes	☐ High Cholesterol	☐ Asthma	☐ Drug Abuse
☐ Headaches/Migraine	☐ Muscle or Joint Problems	☐ Stroke	☐ Tuberculosis
☐ Sudden Infant Death	☐ Arthritis	☐ Alcoholism	☐ Seizures
☐ Early Deafness	☐ Cancer	☐ Heart Disease	☐ Cystic Fibrosis

Social History

Exposed to cigarette smoke at home? Yes No

Primary guardian(s): _____

Relationship: _____

Signature

_____ _____ _____

Guardian's Signature **Guardian's Printed Name** **Date**