Health History Date: _____

Student Name:_____ _____ ID#
Last Name First Name phone

Yes No ***Please Note: All information provided by you will be kept in strictest confidence***

1 ☐ ☐ Do you have any concerns about your child's general health (eating and sleeping habits, weight, teeth, etc.)?
2 ☐ ☐ Does your child have any other specific illness or problem?
3 ☐ ☐ Does your child have any allergies (food, insects, medications, etc.)?
4 ☐ ☐ Does your child take any medication (daily or occasionally)?
5 ☐ ☐ Does your child have any problem with hearing, vision or speech (glasses, contacts, ear tubes, hearing aids)?
6 ☐ ☐ Has your child had any hospitalization, operation or major illness (specify problem)?
7 ☐ ☐ Has your child had any significant injury or accident (specify problem)?
8 ☐ ☐ Would you like to discuss anything about your child's health?

Mark an (x) in the box next to the medical condition listed below that applies to your health history:

☐ Anemia ☐ Pneumonia **Current Medications**
☐ Arthritis ☐ Poliomyelitis ☐
☐ Asthma ☐ Psychological Disorder ☐
☐ Bleeding Disorder ☐ Rheumatic Fever ☐
☐ Bronchitis ☐ Scarlet Fever ☐
☐ Chicken Pox ☐ Sinusitis ☐
☐ Convulsions/Neurological Disorders ☐ Sleep Walking ☐
☐ Diabetes ☐ Thyroid Condition ☐
☐ Eating Disorders ☐ Tuberculosis ☐
☐ Epilepsy ☐ Tumors ☐
☐ Eye Ailments ☐
☐ Fainting **Visual** ☐
☐ Frequent Colds ☐ Eye Glasses ☐
☐ German Measles ☐ Contact Lenses ☐
☐ GI / Stomach Problems ☐
☐ Headaches **Allergies** ☐
☐ Heart Ailments ☐ Hay Fever ☐
☐ Kidney Ailments ☐ Insect Stings
☐ Measles ☐ Penicillin
☐ Mononucleosis ☐ Other _____
☐ Motion Sickness (Vertigo) ☐ Other _____
☐ Mumps☐ Orthopedic Fractures

Primary Care Physician:
Name_____Address_____ Ph.#_____
Insurance Name _____Policy #_____

X Parent Signature DATE: