

Health History

Student/child name:	DOB:
---------------------	------

IDENTIFYING INFORMATION				
Age:	Sex:	Grade:		
Mother's Name & Phone:		e-mail:		
Father's Name & Phone:		e-mail:		
Child lives with: Both Parents Mother Father Other (explain)				
Child's health care coverage: Medicaid CHP+ Private None				
Primary Health Care Provider:				Phone:
Date of last check up:		other medical visit:		Reason for visit:
Please list other Medical Specialist (neuro, ortho, allergist, etc):				
Dentist:		Date of Last Dental exam:		

PREGNANCY AND BIRTH				
Which trimester medical care began: 1 st 2 nd 3 rd Length of pregnancy: full term or weeks				
Medications/alcohol/drug use during pregnancy? No Yes Explain:				
Any Complications with pregnancy? No Yes Explain:				
Length of labor hrs. Any Complications? No Yes Explain:				
Baby cried/breathed: immediately / within 1 minute / within 5 minutes / longer than 5 minutes				
Explain any health issues at birth:				
Did baby require extra stay in hospital? No Yes Explain:				
Birth Weight: lbs. oz				

DEVELOPMENTAL HISTORY	Yes	No	Comments
Did your child crawl by 9 months?			
Did your child walk by 18 months?			
Did your child say words by 15 months?			
Was your child toilet trained by 3½ years?			
Were there problems with gross motor skills (balance/coordination)?			
Were there problems with fine motor skills (buttons, handwriting, picking something up)?			
Any other concerns about your child's development?			

ILLNESSES, HOSPITALIZATIONS, SURGERIES, AND/OR ACCIDENTS
Major Illnesses:
Hospitalization/Surgeries:
Accidents/Injuries:

Body System History (Explain if "yes")	Yes	No	Comments
Teeth: Dental concerns?			
Ears: Do you have concerns about your child's hearing?			
Known hearing condition? (hearing loss/hearing aids/PE tubes)			
History of chronic ear infections? Date of last infection:			
Eyes: Does your child have problems seeing?			
Does your child wear glasses or contacts? Last exam:			
Cardiac: Does your child have any heart problems?			
Does your child fatigue easily or have poor endurance?			
Respiratory: History of breathing problems/asthma?			
Is he/she prone to upper respiratory infections?			

Health History

Student/child name:	DOB:
---------------------	------

Body System History (Explain if "yes")	Yes	No	Comments
Gastrointestinal/Urinary: Any problems going to the bathroom?			
Daytime or nighttime incontinence (trouble staying dry)?			
Constipation / diarrhea / uncontrolled bowel movements?			
Does your child have frequent stomach aches?			
Does your child have dietary/food needs or concerns?			
Do you feel your child gets adequate nutrition (variety of foods)?			
Do you have concerns about your child's weight?			
Skeletal and Muscular: History of broken bones? Which ones & when?			
Does your child have any physical disabilities?			
Are there any restrictions for activity?			
Neurological: History of seizures?			
Does your child have frequent headaches?			
Has your child ever had a head injury or concussion?			
Were they seen by a physician?			
Hospitalized? Yes / No How long? _____			
After injury, symptoms included which of the following: Dizziness / Memory problems / Headaches / Fatigue / None			
Are you concerned about your child's sleeping habits? Sleeps soundly / difficulty going to sleep / difficult to arouse Goes to bed at _____ Gets up at _____			
Are any of the following devices or appliances in the child's bedroom (circle all that apply): TV / Computer/ Gaming Console / None			
Does your child snore?			
Does your child have a limited attention span?			
Do you think your child is distractible?			
Is your child impulsive?			
Concerns about your child's behavior/emotional status?			
Allergies: Does your child have medication allergies?			
Food allergies?			
Insect allergies? (bee, wasp sting)			
Environmental allergies?			
Is your child seeing an allergist?			
Medications: current medications? (Prescription/over-the-counter)			
List medications, dose, and time taken:			

**This information is confidential and will only be shared with personnel responsible for the general/special education and health care of your child.

Name & Signature of person completing this form	(Interpreter if applicable)	Date
Nurse Signature		Date