

Health History

Name of Child _____ Grade _____

1. Check any of the following illnesses the child has had:

- "red" measles rheumatic fever German measles pneumonia
- mumps whooping cough chicken pox

Circle the answer:

- 2. Has the child had more than six colds or throat infections with a fever, a year? No yes
- 3. Has the child had any trouble with ears or hearing? No Yes
- 4. Has the child had any trouble with eyes or seeing? No Yes
- 5. Has the child had any trouble with teeth? No Yes
- 6. Has the child ever had a convulsion or fit? No Yes
- 7. Has the child ever had a fainting spell? No Yes
- 8. Does the child complain of headaches? No Yes
- 9. Has a doctor ever said the child had a heart murmur? No Yes
- 10. Do any foods disagree with the child? No Yes
- 11. Does the child often have diarrhea? No Yes
- 12. Has constipation ever been much of a problem? No Yes
- 13. Has the child ever had worms or parasites? No Yes
- 14. Have you ever seen blood in the child's stools (bowel movements)? No Yes
- 15. Has the child ever had yellow jaundice or trouble with the liver? No Yes
- 16. Does the child have any problem with urination? No Yes
- 17. Does the child complain of stomachaches? No Yes
- 18. Does the child have any skin problems? No Yes
- 19. Has the child ever had eczema or allergy? No Yes
- 20. Has the child ever had an allergy or reaction to any medicine or injection? No Yes
- 21. Has the child ever had asthma or wheezing? No Yes
- 22. Does the child seem to have trouble breathing through the nose? No Yes
- 23. Does the child snore at night? No Yes
- 24. Has the child ever complained of pain in the arms or legs? No Yes
- 25. Has the child ever had swelling of any joints or limping? No Yes
- 26. Has there ever been any trouble with the child's blood? No Yes
- 27. Does the child have any trouble sleeping? No Yes

Medical History

1. Has the child ever been in the hospital or had an operation? No Yes
 When? What for? Name of Hospital:

2. Has the child had any other illnesses, accidents, broken bones or fractured bones? No Yes

3. Is the child receiving treatment at a hospital, clinic or doctor at the present time? No Yes
 Where? What for?

4. Is the child taking any medicines, pills or vitamins now? No Yes
 What for? How often?

_____ Date

_____ Parent/Guardian Signature

_____ Daytime phone