**HEALTH HISTORY FORM**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please check yes or no.**

Bee sting allergies [ ] yes [ ]  no Seizures (epilepsy) [ ] yes [ ] no Psychological disorder [ ] yes [ ] no

Anemia [ ] yes [ ] no Stomach problems [ ] yes [ ] no      Thyroid disease [ ] yes [ ] no

Seasonal allergies [ ] yes [ ] no Heart problems [ ] yes [ ] no   Frequent sore throats [ ] yes [ ] no

Daily Medicines will not be dispensed at the School Owl Health Extension. They will still be dispensed in the office.

Asthma [ ] yes [ ] no      Bladder problems [ ] yes [ ] no      Nosebleeds [ ] yes [ ] no

Diabetes [ ] yes [ ] no      Cancer [ ] yes [ ] no Backaches [ ] yes [ ] no

Eczema/rashes [ ] yes [ ] no Headaches/migraines [ ] yes [ ] no      Frequent urination [ ] yes [ ] no

ADD/ADHD [ ] yes [ ] no High blood pressure [ ] yes [ ] no      Kidney disease [ ] yes [ ] no

Sickle cell disease/trait [ ] yes [ ] no Fainting [ ] yes [ ] no      Shortness of breath [ ] yes [ ] no

Pounding of heart [ ] yes [ ] no Pneumonia [ ] yes [ ] no      Learning Disability [ ] yes [ ] no

Depression [ ] yes [ ] no Anxiety [ ] yes [ ] no

Does anyone smoke in the household? [ ] yes [ ] no

If additional space needed for below questions, please use the back of the form.

1. Student’s Daily Medications? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Condition for Medications? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Any Medication Allergies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Any Food Allergies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Any Surgeries? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Any Hospitalizations? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. Other health problems? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- |
| Family Medical History Check any illnesses that relatives (i.e. mother, father, aunt, uncle, grandparents, sibling) and note which relative has them |
| [ ]  Heart Problems | [ ]  Cancer |
| [ ]  Cholesterol | [ ]  Diabetes (high blood sugar) |
| [ ]  High Blood Pressure | [ ]  Stroke |
| [ ]  Asthma/Emphysema/Bronchitis | [ ]  Seizures |
| [ ]  Death under age 50 – Cause: | [ ]  Kidney or Thyroid Disease |
| [ ]  Sickle Cell Anemia/Blood problems | [ ]  Other |

**Signature (Parent/Guardian): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_­­\_\_**