**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: \_\_\_\_\_\_\_\_\_­­\_\_**