



HEALTH HISTORY FORM 2011-2012

CHILD'S NAME: _____

PERSON PROVIDING THIS INFORMATION: _____ RELATIONSHIP: _____

CAMPUS: _____ GRADE: _____

HOSPITALIZATIONS AND ILLNESSES	YES	NO	EXPLAIN "YES" ANSWERS
1. Has child ever been hospitalized or operated on?			
2. Has child ever had a serious accident (broken bones, head injuries, falls, burns, poisoning)?			
3. Has child ever had a serious illness?			

HEALTH PROBLEMS	YES	NO	EXPLAIN "YES" ANSWERS
4. Does child have frequent: <input type="checkbox"/> urinary infections or trouble urinating <input type="checkbox"/> sore throat <input type="checkbox"/> cough <input type="checkbox"/> stomach pain, vomiting, diarrhea?			
5. Does child have difficulty seeing (squint, cross eyes, look closely at books)?			
6. Is child wearing (or supposed to wear) glasses?			
7. Does child have problems with ears/hearing (pain in ear, frequent earaches, discharge, rubbing)			
8. Has child ever had a convulsion or seizure?			
9. Is child taking any medication now?			
10. Is child now being treated by a physician or a dentist?			
11. Has child had: <input type="checkbox"/> boils <input type="checkbox"/> chickenpox <input type="checkbox"/> eczema <input type="checkbox"/> measles <input type="checkbox"/> Mumps <input type="checkbox"/> scarlet fever <input type="checkbox"/> whooping cough <input type="checkbox"/> German measles?			
12. Has child had: <input type="checkbox"/> hives <input type="checkbox"/> polio?			
13. Has child had: <input type="checkbox"/> asthma <input type="checkbox"/> bleeding tendencies <input type="checkbox"/> diabetes <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> epilepsy <input type="checkbox"/> heart/blood vessel disease <input type="checkbox"/> Liver disease <input type="checkbox"/> sickle cell disease?			
14. Does child have any allergy problem (rash, itching, swelling, difficulty breathing, sneezing)? a. When eating any foods? _____ b. When taking any medication? _____ c. When near animals furs insects dust etc? _____			
15. Does your child have any other medical conditions? _____ Did a doctor or other health professional tell you the child has this problem? _____ When was your child last seen by a doctor for this: _____			

16. Describe any special needs your child will require in daily activities:

17. Are there any conditions we haven't talked about that get in the way of the child's everyday activities?			
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FOR PARENTS OF A CHILD WITH ASTHMA

18. When was your child diagnosed with asthma?
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19. What triggers your child's asthma attacks? Please check all that apply. <input type="checkbox"/> Illness <input type="checkbox"/> Emotions <input type="checkbox"/> Medications <input type="checkbox"/> Foods <input type="checkbox"/> Fatigue <input type="checkbox"/> Weather <input type="checkbox"/> Exercise <input type="checkbox"/> Chemical Odors <input type="checkbox"/> Cigarette or other Smoke
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20. How many times has your child been hospitalized overnight or longer for asthma in the past 12 months?

21. Does your child have any special needs related to asthma while at school (disregard if listed in the previous section)?

PHYSICAL, PSYCHOLOGICAL AND SOCIAL DEVELOPMENT

22. Does your child worry a lot, or is he/she very afraid of anything? If yes, what things seem to cause him or her to worry or to be afraid:			
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23. Does your child have any difficulties saying what he/she wants to do or do you have any trouble understanding your child? If yes please describe:			
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24. Have there been any big changes in your child's life in the last six months? If yes, please describe:			
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25. Is there anything else you would like us to know about your child? If yes, please describe:			
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