# HEALTH HISTORY FORM 2010-2011

CHILD'S NAME: ______________________________________________

PERSON PROVIDING THIS INFORMATION: ______________________ RELATIONSHIP: ______________

| 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** | | | |
| 4. Does child have frequent: ☐ urinary infections or trouble urinating ☐ sore throat ☐ cough ☐ 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: ☐ boils ☐ chickenpox ☐ eczema ☐ measles ☐ Mumps ☐ scarlet fever ☐ whooping cough ☐ German measles? | | | |
| 12. Has child had: ☐ hives ☐ polio? | | | |
| 13. Has child had: ☐ asthma ☐ bleeding tendencies ☐ diabetes ☐ Rheumatic fever ☐ epilepsy ☐ heart/blood vessel disease ☐ Liver disease ☐ sickle cell disease? | | | |
| 14. Does child have any allergy problem (rash, itching, swelling, difficulty breathing, sneezing)?<br>a. When eating any foods?<br>______________________________<br>b. When taking any medication? ______________________<br>c. When near animals furs insects dust etc? ______________ | | | |
| 15. Does your child have any other medical conditions? ______________<br>Did a doctor or other health professional tell you the child has this problem?__________<br>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? | | | |

**FOR PARENTS OF A CHILD WITH ASTHMA**

18. When was your child diagnosed with asthma?

19. What triggers your child's asthma attacks? Please check all that apply.

☐ Illness ☐ Emotions ☐ Medications ☐ Foods ☐ Fatigue ☐ Weather ☐ Exercise ☐ Chemical Odors
☐ Cigarette or other Smoke

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