

Student Name \_\_\_\_\_

Date Completed \_\_\_\_\_

STUDENT'S HEALTH HISTORY (Entry)

A. Prenatal Health History

Put A Circle Around  
The Answer and Explain

- 1. Did the mother have any illness during the pregnancy? NO YES
Explain \_\_\_\_\_
2. Did the mother take any medicines or drugs (other than iron or vitamins) during the pregnancy? NO YES
What medication and why? \_\_\_\_\_
3. Did the baby come on time? NO YES
Explain \_\_\_\_\_

B. Developmental History

- 1. What was your baby's birth weight? NO YES
2. Did your baby have any trouble while in the hospital? NO YES
Explain : \_\_\_\_\_
3. Did your baby have any special problems in the first six months? NO YES
4. At what age did your child sit alone without support?
5. At what age did your child walk alone without support?
6. At what age did your child begin to say two or three words together?
7. Can your child use the toilet without help now? NO YES
8. If your child has stopped wetting the bed, at what age did they stop?

C. Family Health History

- 1. Circle the diseases/disorders that your child's relatives have/had and who has/had them : Allergy
Mother.....Father.....Grandparents.....Aunts.....Uncles.....Brothers.....Sisters.....
Asthma .....Mother.....Father.....Grandparents.....Aunts.....Uncles.....Brothers.....Sisters
Bee Sting Allergy .....Mother.....Father.....Grandparents.....Aunts.....Uncles.....Brothers.....Sisters
Alcohol Addiction .....Mother.....Father.....Grandparents.....Aunts.....Uncles.....Brothers.....Sisters
Drug Addiction .....Mother.....Father.....Grandparents.....Aunts.....Uncles.....Brothers.....Sisters
Cancer .....Mother.....Father.....Grandparents.....Aunts.....Uncles.....Brothers.....Sisters
Diabetes .....Mother.....Father.....Grandparents.....Aunts.....Uncles.....Brothers.....Sisters
Heart Disease .....Mother.....Father.....Grandparents.....Aunts.....Uncles.....Brothers.....Sisters
Hypertension .....Mother.....Father.....Grandparents.....Aunts.....Uncles.....Brothers.....Sisters
Mental Health Problem .....Mother.....Father.....Grandparents.....Aunts.....Uncles.....Brothers.....Sisters
Seizures .....Mother.....Father.....Grandparents.....Aunts.....Uncles.....Brothers.....Sisters
Tuberculosis .....Mother.....Father.....Grandparents.....Aunts.....Uncles.....Brothers.....Sisters
Lead Poisoning .....Mother.....Father.....Grandparents.....Aunts.....Uncles.....Brothers.....Sisters
Sickle Cell Disease .....Mother.....Father.....Grandparents.....Aunts.....Uncles.....Brothers.....Sisters
Vision disorder .....Mother.....Father.....Grandparents.....Aunts.....Uncles.....Brothers.....Sisters
glasses.....Mother.....Father.....Grandparents.....Aunts.....Uncles.....Brothers.....Sisters
Hearing disorder .....Mother.....Father.....Grandparents.....Aunts.....Uncles.....Brothers.....Sisters
Learning Problems .....Mother.....Father.....Grandparents.....Aunts.....Uncles.....Brothers.....Sisters

ADD/ADHD .....Mother.....Father.....Grandparents.....Aunts.....Uncles.....Brothers.....Sisters  
 Anemia .....Mother.....Father.....Grandparents.....Aunts.....Uncles.....Brothers.....Sisters  
 Other inherited or  
 family disease .....Mother.....Father.....Grandparents.....Aunts.....Uncles.....Brothers.....Sisters

2. Family Members : **Please list all family members**

(Note any special relationship such as step-parent, adopted, foster-child, etc.)

| Relationship | Age | Name | Occupation<br>or School | Grade Reached<br>in School |
|--------------|-----|------|-------------------------|----------------------------|
| Mother       |     |      |                         |                            |
| Father       |     |      |                         |                            |
| Brothers     |     |      |                         |                            |
| Brothers     |     |      |                         |                            |
| Brothers     |     |      |                         |                            |
| Sisters      |     |      |                         |                            |
| Sisters      |     |      |                         |                            |
| Sisters      |     |      |                         |                            |

3. Have any members of the family died ? ..... NO YES  
 (Not Miscarriages)
4. How many people live in your house (including the child) ? .....
5. Are there any family problems such as problems with housing,  
 employment, food, etc ..... NO YES  
 Explain: .....

D. Health History - Continued

1. Check ( ) any of the following illnesses the child has had and at what age:
- |                 |                          |            |                         |                          |            |
|-----------------|--------------------------|------------|-------------------------|--------------------------|------------|
| "Red Measles"   | <input type="checkbox"/> | Age: _____ | German or 3 Day"Measles | <input type="checkbox"/> | Age: _____ |
| Whooping Cough  | <input type="checkbox"/> | Age: _____ | Chicken Pox             | <input type="checkbox"/> | Age: _____ |
| Rheumatic Fever | <input type="checkbox"/> | Age: _____ | Pneumonia               | <input type="checkbox"/> | Age: _____ |

Put a circle around  
the answer

2. Has your child had more than six colds or throat infections, with a fever, a year?..... NO YES  
 Explain : .....
3. Has your child had any trouble with their ears or hearing ?..... NO YES  
 Explain : .....
4. Has your child had any trouble with their eyes or seeing ?..... NO YES  
 Explain : .....

|       |   |    |     |
|-------|---|----|-----|
| 5.    | Has your child had any trouble with their teeth ? .....                               | NO | YES |
|       | Explain : _____   |    |     |
| 6.    | Has your child had a convulsion (seizure) ? .....                                     | NO | YES |
|       | Explain: _____  |    |     |
| 7.    | Has your child ever fainted ?.....  | NO | YES |
| 8.    | Does your child ever complain of headaches ? .....                                    | NO | YES |
| 9.    | Has a doctor ever said your child had a heart murmur ? .....                          | NO | YES |
| 10.   | Does your child have trouble keeping up actively with other children ? .....          | NO | YES |
|       | Explain : _____   |    |     |
| 11.   | Do any foods disagree with your child ? .....   | NO | YES |
|       | What foods, and how do they react ? _____   |    |     |
| _____ |   |    |     |
| 12.   | Does your child often have diarrhea ? .....   | NO | YES |
| 13.   | Has constipation ever been much of a problem for your child ? .....                   | NO | YES |
| 14.   | Has your child ever had worms or parasites ? .....                                    | NO | YES |
| 15.   | Have you ever seen blood in your child's stools (bowel movements) ? .....             | NO | YES |
|       | Explain : _____   |    |     |
| 16.   | Has your child ever had yellow jaundice or trouble with their liver ? .....           | NO | YES |
|       | Explain when and the treatment : _____  |    |     |
| 17.   | Does your child complain of belly aches frequently ? .....                            | NO | YES |
|       | Explain: _____  |    |     |
| 18.   | Does your child have any problems with passing water (urinating) ? .....              | NO | YES |
|       | Explain : _____   |    |     |
| 19.   | Does your child have any skin problems ? .....  | NO | YES |
|       | Explain : _____   |    |     |
| 20.   | Has your child ever had eczema or allergy ? .....                                     | NO | YES |
|       | What caused their allergy ? _____   |    |     |
|       | How did they react ? _____  |    |     |
| 21.   | Has your child ever had wheezing ? .....  | NO | YES |
|       | Explain : _____   |    |     |
| 22.   | Has your child ever had asthma ? .....  | NO | YES |
|       | How is it treated ? _____   |    |     |
| 23.   | Has your child ever had an allergy or reaction to any medicines or injections ? ..... | NO | YES |
|       | What was the medicine or injections ? _____   |    |     |
|       | How did they react ? _____  |    |     |
| 24.   | Has your child ever been stung by a wasp, bee or yellow jacket? .....                 | NO | YES |
|       | Did they have a reaction, and if so, how did they react ? .....                       | NO | YES |
|       | What was the treatment that they were given ? _____                                   |    |     |
| 25.   | Does your child seem to have trouble breathing through their nose ? .....             | NO | YES |
| 26.   | Have your been told that your child's tonsils or adenoids are enlarged ?.....         | NO | YES |
| 27.   | Does your child snore at night ? .....  | NO | YES |
| 28.   | Has your child ever complained of pain in their arms or legs ? .....                  | NO | YES |
|       | When does this occur ? _____  |    |     |

29. Has your child ever had swelling of any joints that caused limping ? ..... NO YES  
 Explain: \_\_\_\_\_
30. Has there ever been any problem with the child's blood ? ..... NO YES  
 Explain : \_\_\_\_\_
31. Has your child ever eaten paint or plaster or anything else which is not food ? ..... NO YES  
 Where there any problems from it ? ..... NO YES  
 What happened ? \_\_\_\_\_
32. Does your child have any trouble sleeping ? ..... NO YES  
 Explain : \_\_\_\_\_
33. Does your child have trouble going to sleep ? ..... NO YES  
 Explain : \_\_\_\_\_
34. Has your child ever had a skin test for T.B. (Tuberculosis) ? ..... NO YES  
 When ? \_\_\_\_\_ Was the result normal ? ..... NO YES
35. Do you have concerns about your child's eating habits ? ..... NO YES  
 What are your concerns ? \_\_\_\_\_
36. Has your child attended a preschool program ? ..... NO YES  
 Where ? \_\_\_\_\_  
 How many years has your child attended? \_\_\_\_\_

E. Put a circle around the number any of the following things which worry you about your child:

- |  |   |
|--|---|
| 1. Bed wetting   | 14. Temper tantrums                                   |
| 2. Wetting during the day                                | 15. Contrary or stubborn                              |
| 3. Thumb sucking   | 16. Disobedient                                       |
| 4. Stammering or stuttering                              | 17. Lying   |
| 5. High strung or easily upset?                          | 18. Selfish in sharing                                |
| 6. Too restless  | 19. Jealous of brothers and sisters                   |
| 7. Shy   | 20. Fighting with other children                      |
| 8. Sad or sulky  | 21. Purposely destroys things                         |
| 9. Feelings easily hurt                                  | 22. Eating habits                                     |
| 10. Wanting too much attention                           | 23. Bowels  |
| 11. Wanting too much comfort or support<br>from a parent | 24. Unable to follow directions                       |
| 12. Day Dreams   | 25. Shifting from activity to activity frequently     |
| 13. Nightmares   | 26. Any other problems not mentioned?<br>What ? _____ |

Health History obtained from \_\_\_\_\_  
 Parent/Guardian's Name

Interviewed by \_\_\_\_\_  
 School Nurse/Practitioner