MEDICAL HISTORY

Student's Name: ____ Date:________________

Address: ____

Date of Birth: _________________ Parent Completing Form:_____________________________________

STUDENT'S HEALTH DATA

1. Has the child had any of the following illnesses? Please check and indicate date.

	Date		Date		Date
Anemia		German Measles		Kidney disease	
Chicken Pox		Allergies		Asthma	
Diabetes		Measles		Frequent colds, sore throats, ear infections	
Epilepsy		Mumps		Rheumatic Fever	
Heart disease		Pneumonia		Scarlet Fever	

2. Have you ever notice a hearing difficulty in the student? Yes ______ No ______

3. Any vision problem that you are aware of? Yes ______ No ______

4. Has child ever visited the dentist?

5. Has the child ever been involved in a serious accident of any kind? Yes ______ No ______
If yes, explain (including any serious head injury).

6. Has the student ever been hospitalized? Yes ______ No ______
When _________________ Where ____
For what reason?

How did he/she react to this?

7. Is he/she presently on any medication, prescribed or over-the-counter?

PREGNANCY / BIRTH HISTORY

1. Did the mother take alcohol, drugs or smoke during pregnancy? Yes ______ No ______
If yes, give details:

2. Any viral infections, flu, or rashes during pregnancy? Yes ______ No _____

3. Any complications during pregnancy or during labor? Yes ______ No ______
(Example: bleeding)

4. Was the child: Full Term ______ Premature (give month) __________
Child's weight at birth ___________ Was child in incubator? __________

5. Normal birth? _______ Breech birth ________ Caesarean __________

6. Did the child require special medical treatment following birth?

FAMILY HISTORY

1. Does anyone in the family have any of the following illnesses? (Please check illness and note who in the family has it.)

Illness	Check	Who
Seizure disorder		
Severe allergies		
Diabetes		
Heart disease		
Lung disease (including asthma)		
Any other chronic illness		

2. Has anyone in the family had any mental disorder (including alcohol or drug abuse)?
If yes, please explain.

3. Did either parent or other siblings experience learning difficulties in school?
If yes, please explain.

4. Has there been a serious illness or a death of anyone close to the student, such as father, mother, grandparent, sibling, or close friend? Yes __ No ___
Who Age of Student Student's Reaction

5. In how many different homes has the family lived within the past 4 years?

6. Have there been any circumstances in this child's life that you believe were hard for the student. If yes, please explain.

Date

Parent Signature