

BRADFORD AREA SCHOOL DISTRICT

Student's Health History

Student's name: _____

Date of Birth: _____

Date completed: _____

Pre-Natal Health History

Circle answer

- | | | |
|---|-----|----|
| 1. Did the mother have any illness during the pregnancy? | Yes | No |
| 2. Did the mother take any medicines or drugs (other than iron or vitamins) during the pregnancy? | Yes | No |
| 3. Did the baby come on time? | Yes | No |

Developmental History

- | | |
|---|-----------|
| 1. What was the baby's birth weight? | _____ |
| 2. Did the baby have any trouble while in the hospital? | Yes No |
| 3. Did the baby have any special problems in the first 6 months? | Yes No |
| 4. At what age did the child sit alone without support? | _____ |
| 5. At what age did the child walk alone without support? | _____ |
| 6. At what age did the child begin to say two or three words together? | _____ |
| 7. Can the child use the toilet without help? | Yes No |
| 8. If the child has stopped wetting the bed, at what age did he/she stop? | _____ |

Family Health History

Circle any of the following diseases that this child's parents, grandparents, aunts, uncles, brothers or sisters have had:

Allergies, asthma, cancer, drug or alcohol addiction, diabetes, heart disease, nervous breakdown, seizures, tuberculosis, lead poisoning, sickle cell, vision, hearing, learning problems, anemia, other inherited or family diseases.

Special Health Needs

Circle answer

1. Has the pupil ever had any serious illness or operation?

Yes No

What? _____

When? _____

2. Is the pupil going to a hospital, clinic or doctor now?

Yes No

What for? _____

When? _____

3. Apart from vitamins, is the pupil taking any medicine, tablets or drugs?

Yes No

What? _____

What for? _____

4. Is the pupil allergic to anything, such as foods, plants insects or medicine?

Yes No

What? _____

5. Has the pupil had any convulsions (fits, seizures) in the past year?

Yes No

How many? _____

Treatment _____

6. Does the pupil need a special diet or have any food problem?

Yes No

Give details _____

7. Does the pupil have any special health needs or problems the school should know?

Yes No

What? _____

8. Has the child had any other illnesses, accidents, broken bones?

Yes No

When? _____

What was the problem? _____

9. Has the child ever been seen by a dentist?

Yes No

Name of dentist _____

Signature of Mother/Guardian

Date

Signature of Father/Guardian

Date

1. Check any of the following illnesses the child has had:

"Red" Measles _____

German (3 day) Measles _____

Whooping Cough _____

Chicken Pox _____

Rheumatic Fever _____

Pneumonia _____

Circle answer

- | | | |
|--|-----|----|
| 2. Has the child had more than 6 colds or throat infections with a fever, within a year? | Yes | No |
| 3. Has the child had any trouble with ears or hearing? | Yes | No |
| 4. Has the child had any trouble eyes or seeing? | Yes | No |
| 5. Has the child had any trouble with teeth? | Yes | No |
| 6. Has the child ever had a convulsion (fit or seizure)? | Yes | No |
| 7. Has the child ever had a fainting spell? | Yes | No |
| 8. Does the child complain of headaches? | Yes | No |
| 9. Has a doctor ever said the child had a heart murmur? | Yes | No |
| 10. Does the child have trouble keeping up with other children? | Yes | No |
| 11. Do any foods disagree with the child? | Yes | No |
| 12. Does the child often have diarrhea? | Yes | No |
| 13. Has constipation ever been much of a problem for this child? | Yes | No |
| 14. Has the child ever had worms or parasites? | Yes | No |
| 15. Have you ever seen blood in the child's stools (bowel movements)? | Yes | No |
| 16. Has the child ever had yellow jaundice or trouble with the liver? | Yes | No |
| 17. Does the child complain of belly-aches? | Yes | No |
| 18. Does the child have any problems with urination? | Yes | No |
| 19. Does the child have any skin problems? | Yes | No |
| 20. Has the child ever had eczema or allergies? | Yes | No |
| 21. Has the child ever had asthma or wheezing? | Yes | No |
| 22. Has the child ever had an allergy or reaction to any medicines or injections? | Yes | No |
| 23. Does the child seem to have trouble breathing through the nose? | Yes | No |
| 24. Does the child snore at night? | Yes | No |
| 25. Has the child ever complained of pain in the arms or legs? | Yes | No |
| 26. Has the child ever had swelling of any joints or limping? | Yes | No |

- | | | |
|---|-----|----|
| 27. Has there ever been any trouble with the child's blood? | Yes | No |
| 28. Has the child ever eaten paint or plaster or anything, which is not food? | Yes | No |
| 29. Does the child have any trouble sleeping? | Yes | No |
| 30. How does the child put himself to sleep? | | |

- | | | |
|---|-----|----|
| 31. Has the child ever had a skin test for TB (Tuberculosis)? | Yes | No |
| 32. Was the result normal? | Yes | No |

33. What does the child usually eat for:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

How many snacks a day? _____

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

- | | |
|---|---|
| 1. Bedwetting | 13. Nightmares |
| 2. Wetting during the day | 14. Temper tantrums |
| 3. Thumb sucking | 15. Contrary or stubborn |
| 4. Stammering or stuttering | 16. Disobedient |
| 5. High strung or easily upset | 17. Lying |
| 6. Too restless | 18. Selfish in sharing |
| 7. Shy | 19. Jealous of brothers and sisters |
| 8. Sad and sulky | 20. Fighting with other children |
| 9. Feelings easily hurt | 21. Purposely destroys things |
| 10. Wanting too much attention | 22. Feeding |
| 11. Wanting too much comfort or support from parent | 23. Bowels |
| 12. Day dreams | 24. Any other problems not mentioned? _____ |

Health History obtained from:

Parent/Guardian

Health Provider