Original Date:
Dates Revised:
(Please leave blank for office use only)

HEALTH HISTORY QUESTIONNAIRE

Student Name: ☐ M ☐ F	DOB:
Primary Physician:	Non-medication Allergies:
Parent Signature:	Response to Allergens:

Please answer all questions and include any **PAST OR PRESENT** health problems. All questions contained in this questionnaire are strictly confidential and will be communicated only with those who have a need to know.

PERSONAL HEALTH HISTORY

Childhood illness:	☐ Asthma ☐ GERD ☐ Scoliosis ☐ Kidney/Bladder Infections ☐ Diabetes ☐ Heart murmur ☐ Seizures ☐ Cancer ☐ Eczema ☐ Constipation ☐ Developmental Delay ☐ Autism Spectrum Disorder ☐ ADD / ADHD ☐ Hyper/hypothyroid ☐ Frequent Ear Infections ☐ Hearing Loss ☐ Glasses/Contacts ☐ Frequent Nosebleeds ☐ Sleep Disturbances ☐ N/A

Please elaborate on any of the illnesses checked above (ex: when diagnosed, type, past or current illness, etc...)

List any additional medical problems that doctors have diagnosed and when (ex: concussion, skin problems, orthopedic problems, blood disorders, migraines, etc...)

Surgeries		
Year	Reason	Hospital

List ALL of student's prescribed medications and over-the-counter medications, EVEN IF ONLY GIVEN AT HOME (Include vitamins as well)		
Medication Name	**Strength**	**Frequency Taken**

Allergies to medications	
Medication Name	Reaction