GRANBY PUBLIC SCHOOLS HEALTH HISTORY

CHILD'S NAME_____ DATE OF BIRTH_____

I. BIRTH HISTORY

(please circle yes or no)

Were there any problems during pregnancy?
NO YES
If **yes**, describe:

Birth Weight_____

Was this child premature? **NO YES**

Were there any problems at the time of birth or in the next week? **NO YES**

Did your child come home from the hospital with you? **NO YES**
If **no**, explain:

II. PAST MEDICAL HISTORY

Has your child ever been a patient in the hospital?
NO YES
If **yes**, list dates, hospital and reason.

Has your child ever been to the Emergency Room?
NO YES
If **yes**, why?

Has your child ever had a seizure with an elevated temperature? **NO YES**

CHILDHOOD ILLNESSES

Has your child had any of the following?

Meningitis **NO YES**

Encephalitis **NO YES**

Chicken Pox **NO YES**

Scarlet Fever **NO YES**

Rheumatic Fever **NO YES**

Pneumonia **NO YES**

Fifths Disease **NO YES**

ALLERGIES

Has your child ever had problems with any of the following?

Food Allergy **NO YES**
If yes, to what?

Drug or medication Allergy **NO YES**
If yes, to what?

Severe reaction to insect stings **NO YES**
If yes, explain:

Does your child require Medication (Benadryl or epi-pen) for the above allergies NO YES

SPECIAL HEALTH CARE

Has your child ever undergone any special tests for health problems? **NO YES**

Has your child ever been seen by a specialist?
NO YES
If yes, who and for what reason?

Is your child under the care of a specialist now?
NO YES

Has your child seen a dentist for general checkups and dental cleaning? **NO YES**
If yes, how often?

Does your child have any treatments/procedures done on a daily basis? **NO YES**
If yes, please explain:

III. PRESENT MEDICAL HISTORY

Does your child have a good appetite? **NO YES**

Excessive thirst? **NO YES**

Sleep problems? **NO YES**

Physical restrictions? **NO YES**

Trouble staying on task? **NO YES**

Taking Medications? **NO YES**
If yes, list.

SKIN

Does your child have any problems with rashes?
NO YES

Does your child have eczema? NO YES

Does your child bruise easily? NO YES

Does your child get hives? NO YES

EYES

Does your child have any problems with his/her eyes? NO YES

Does your child's eyes turn in or out when tired?
NO YES

Does your child wear glasses? NO YES

EARS, NOSE AND THROAT

Has your child had any ear infections or drainage?
NO YES
If yes, how many?

Does your child have trouble hearing? NO YES

Frequent nosebleeds? NO YES

Frequent sore throats? NO YES

Frequents colds? NO YES

Asthma or wheezing? NO YES

GASTROINTESTINAL

Does your child have stomach aches? NO YES

Frequent diarrhea? NO YES

Trouble with constipation? NO YES

Vomit frequently? NO YES

CARDIOVASCULAR

Have you ever been told your child has a heart murmur? NO YES

URINARY

Does your child have urinary problems? NO YES

Wetting during the day NO YES

SKELETAL

Does your child complain of pains in his/her legs, arms, back or joints? NO YES

NEUROMUSCULAR

Does your child lose his/her balance? NO YES

Any unexplained movements or jerks? NO YES

Any convulsions or seizures? NO YES

Any weakness in his/her body? NO YES

Unusual staring spells? NO YES

Fall down more than most children? NO YES

OTHER PARENT CONCERNS

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