STUDENT HEALTH HISTORY

Student's Name: ________________________________ Date of Birth ___________

Student Lives With: ______________________________ Relationship: ____________

Student's Primary Care Physician: ____

PCP Phone Number: ____

Has your child ever had, or now has, any of the following:

	Yes	No	Explain
Breathing Difficulties			
Frequent Headaches			
Seizures			
Heart Problems			
Bleeding Problems			
Recurring Infections			
Kidney/Bladder Problems			
Head/Neck Injuries			
Stomach/Bowel Problems			
Joint/Bone/Muscle Problems			
Ear/Nose/Throat Problems			
Hearing/Vision Problems			
Emotional/Psychiatric Problems			
Sleeping Problems			
Asthma			
Rheumatic Fever			
Cancer			
Diabetes			
High Blood Pressure			
Drug/Tobacco/Alcohol Usage			
Unexplained Weight Change			
Regular Physical Exercise			
Surgeries			
Allergies			
Medication			

Parent Signature: ____________________________________ **Date:** ______________________