WEST MILFORD TOWNSHIP PUBLIC SCHOOLS
HEALTH HISTORY

School _____ Grade _____

Pupil's Name _____ _____ _____
Last First Middle

Sex _____ Birth Date _____ Birth Place _____

Address _____ Telephone _____

Father's Name _____ Mother's Name _____

Brothers _____Sisters _____ This child is our 1st___ 2nd___3rd___4th___ child in our family.

1. With whom does your child live? _____

2. When was your child's most recent physical examination? _____
Date

Name of Physician/Clinic _____

Purpose of examination: Routine check up _____ Illness/Injury (Specify)_____

3. Please check if your child has had any of the following conditions. Note date of diagnosis and/or occurrence.

Accidents/Injuries: _____; Anemia: _____; Autism:_____;

Allergies: Food _____ Insect Stings _____ Latex _____ Other _____;

Asthma ___ Uses Inhaler ___ Last asthma episode_____; Behavior problem: _____:

Chicken Pox:_____; Congenital defect:_____; Diabetes _____;

Drug sensitivities:_____; Ear infections _____;

Hearing loss:_____; Heart condition:_____: Lead Poisoning: _____;

Seizures/Convulsions:_____; Sickle Cell Anemia:_____; Speech deficit:_____:

Strep Infections:_____; Surgery:_____;

Vision:_____ Corrective lenses_____ Patching_____:

Explain:_____

_____

4. Are there any foods your child must avoid (special diet, food intolerances, religious reasons)?

_____

5. Does your child take medication? _____Name of medication(s)_____

6. Has your child been hospitalized for any reason since birth? Yes _____ No _____

If yes, note date and reason:_____

7. During the pregnancy with this child,
   a) did the mother have any medical problems (e.g., high blood pressure, gestational diabetes, exposure to infections)? Specify:_____
   b) did the mother smoke cigarettes? If yes, note amount_____
   c) drink alcohol? If yes, note amount _____
   d) take any drugs/medication other than vitamins? If yes, give names and frequency

   _____

8. Were there any problems during labor and delivery? Yes _____ No _____

   Comments:_____ Birth Weight at birth ____lb.____oz.

   Did your child leave the hospital when his/her mother left? Yes _____ No _____

   How long did your child remain in the hospital after birth?_____

9. What age did your child: Walk alone? _____; Talk? (2 words together) _____;

   Daytime toilet trained? _____: Bed-wetting a problem? Yes ____ No ____;

10. Do any close relatives in your family have a history of: (indicate relationship to child)

    Anemia _____ Birth Defect_____ Cancer _____

    Diabetes_____ Heart Disease_____ High Blood Pressure _____

    Learning Problems _____ Mental Illness_____

    Seizures/Epilepsy_____ Sickle Cell Anemia _____ Thyroid condition _____

    Other_____

11. Are there any problems in the home that might affect your child's learning? Yes ___ No____

    Comment:_____

12. Is there anything more about your child's health that you think is important for us to know?

    Explain: _____

_____ _____

Parent's/Guardian's Signature Date

_____ _____

Nurse's Signature Date

ep
11/10/10