STUDENT MEDICAL HISTORY

Student Name: ____ Date: ___________________________

1. Physician's name, address, and telephone number:

   ____

   ____

2. Please list any current or previous health problems affecting student:

   ____

   ____

   ____

3. Does the student wear glasses or contacts? _________

   Date of last eye exam: _______________________________

   Optometrist's name, address and telephone number:

   ____

   ____

4. Does the student wear dentures? _________

5. Has the student ever been hospitalized? _________

   Reason: ____ Dates: __________________________

   Physician: __________________________________ Hospital: ____________________________

6. Has the student ever had surgery? _________

   Reason: ____ Dates: __________________________

   Physician: __________________________________ Hospital: ____________________________

7. Has the student ever been involved in an accident? _________

   Injuries: ____

   ____

8. Has the student ever broken a bone? _________

If so, which one(s): ____

____

9. Is the student allergic to any of the following?

_________ Penicillin	_________ Aspirin
_________ Sulfa	_________ Bee or wasp sting
_________ Hornet or other insect	_________ Shellfish
_________ Iodine	_________ Other ____________________

_________ Any other drugs: ____

If so, what are the reactions? ____

____

Other allergies/reactions/treatment (hives, hay fever, eczema, asthma, etc.):

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10. Has the student experienced any of the following? _________

_________ Bed wetting	_________ Stuttering
_________ Nail biting	_________ Head banging
_________ Nightmares	_________ Tics

_________ Other ____

If so, at what age? ____

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11. Please list any fears the student has had (darkness, thunder, death, etc.) and at what ages:

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12. Is the student currently on any medications? _________

Please list medications and dosage: ____

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13. Has the student had any of the following diseases, illnesses, medical problems or disorders?

_______ Anemia (low red blood count)
_______ Asthma
_______ Bladder or Kidney infection
_______ Bone condition
_______ Chicken Pox
_______ Convulsions or seizures
_______ Dermatitis, eczema
_______ Diabetes
_______ Epilepsy
_______ Frequent colds/sore throats
_______ Frequent ear infections
_______ German Measles (3 day)
_______ Heart disorder
_______ Hepatitis
_______ High blood pressure
_______ Meningitis, Encephalitis
_______ Mononucleosis
_______ Mumps
_______ Muscle Weakness
_______ Pneumonia, Bronchitis
_______ Polio
_______ Problems with constipation or diarrhea
_______ Red measles
_______ Rheumatic Fever
_______ Scarlet Fever
_______ Scoliosis
_______ Ulcers
_______ Venereal disease (herpes, gonorrhea, syphilis)
_______ Whooping Cough (croup)

_______ Other: ____

If so, please give dates: ______________________________________

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Vaccine/Test if given as combinations (MMR or MR) enter date in each appropriate box.	Date (1st)	Date (2nd)	Date (3rd)	Date (4th)	Date (5th)
Polio (TOPV)					
DPT and/or TD (Diphtheria, Pertussis, Whooping cough and diphtheria only)					
Measles (Rubella – 10 day, red measles)					
Rubella (German Measles – 3 day measles)					
Mumps					
Tuberculosis skin test					
Tetanus					

Please list any other pertinent medical information not previously listed and any other important information relating to the health history of the student.

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This form represents the complete medical history of the student.

____ ________________________

Parent/Guardian's Signature Date

____ ________________________

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