GRANBY PUBLIC SCHOOLS HEALTH HISTORY

CHILD'S NAME _____ DATE OF BIRTH _____

I. BIRTH HISTORY

Were there any problems during pregnancy? ☐ Yes ☐ No

If **yes,** describe:

Birth Weight _____

Was this child premature? ☐ Yes ☐ No

Were there any problems at the time of birth or in the next week? ☐ Yes ☐ No

Did your child come home from the hospital with you? ☐ Yes ☐ No

If **no,** explain:

II. PAST MEDICAL HISTORY

Has your child even been a patient in the hospital? ☐ Yes ☐ No

If **yes,** list dates, hospital and reason.

Has your child ever been to the Emergency Room? ☐ Yes ☐ No

If **yes,** why?.

Has your child even had a seizure with an elevated temperature? ☐ Yes ☐ No

CHILDHOOD ILLNESSES

Has your child had any of the following?

Meningitis ☐ Yes ☐ No

Encephalitis ☐ Yes ☐ No

Chicken Pox ☐ Yes ☐ No

Scarlet Fever ☐ Yes ☐ No

Rheumatic Fever ☐ Yes ☐ No

Pneumonia ☐ Yes ☐ No

Fifths Disease ☐ Yes ☐ No

ALLERGIES

Has your child had any of the following?

Food Allergy ☐ Yes ☐ No

If **yes,** to what?

Drug or Medication Allergy ☐ Yes ☐ No

If **yes,** to what?

Severe reaction to insect stings ☐ Yes ☐ No

If **yes,** explain?

Does your child require Medication (Benadryl or epi-pen) for the above allergies ☐ Yes ☐ No

SPECIAL HEALTH CARE

Has your child ever undergone any special tests for health problems? ☐ Yes ☐ No

Has your child ever been seen by a specialist? ☐ Yes ☐ No

If **yes,** who and for what reason?

Is your child under the care of a specialist now? ☐ Yes ☐ No

Has your child seen a dentist for general checkups and dental cleanings? ☐ Yes ☐ No

If **yes,** how often?

Does your child have any treatments/ procedures done on a daily basis? ☐ Yes ☐ No

If **yes,** please explain?

CHILDHOOD ILLNESSES

Does your child have a good appetite? ☐ Yes ☐ No

Excessive thirst? ☐ Yes ☐ No

Sleep problems? ☐ Yes ☐ No

Physical restrictions? ☐ Yes ☐ No

Trouble staying on task? ☐ Yes ☐ No

Taking Medications? ☐ Yes ☐ No

If **yes,** please list.

SKIN

Does your child have any problems with rashes? ☐ Yes ☐ No

Does your child have eczema? ☐ Yes ☐ No

Does your child bruise easily? ☐ Yes ☐ No

Does your child get hives? ☐ Yes ☐ No

EYES

Does your child have any problems with his/her eyes? ☐ Yes ☐ No

Does your child's eyes turn in or out when tired? ☐ Yes ☐ No

Does your child wear glasses? ☐ Yes ☐ No

EARS, NOSE AND THROAT

Has your child had any ear infections or drainage? ☐ Yes ☐ No

If **yes,** how many?

Does your child have trouble hearing? ☐ Yes ☐ No

Frequent nosebleeds? ☐ Yes ☐ No

Frequent sore throats? ☐ Yes ☐ No

Frequent colds? ☐ Yes ☐ No

Asthma or wheezing? ☐ Yes ☐ No

GASTROINTESTINAL

Does your child have stomach aches? ☐ Yes ☐ No

Frequent diarrhea? ☐ Yes ☐ No

Trouble with constipation? ☐ Yes ☐ No

Vomit frequently? ☐ Yes ☐ No

CARDIOVASCULAR

Have you ever been told your child has a heart murmur? ☐ Yes ☐ No

URINARY

Does your child have urinary problems? ☐ Yes ☐ No

Wetting during the day? ☐ Yes ☐ No

SKELETAL

Does your child complain of pains in his. her legs, arms, back or joints? ☐ Yes ☐ No

NEUROMUSCULAR

Does your child lose his/her balance? ☐ Yes ☐ No

Any unexplained movements or jerks? ☐ Yes ☐ No

Any convulsions or seizures? ☐ Yes ☐ No

Any weakness in his/her body? ☐ Yes ☐ No

Unusual staring spells? ☐ Yes ☐ No

Fall down more than most children? ☐ Yes ☐ No

OTHER PARENT CONCERNS