WEST MILFORD TOWNSHIP PUBLIC SCHOOLS
HEALTH HISTORY FORM

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(s)? ☐_____ 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 ____lbs.____ozs.

   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