



# Health History – TWO SIDES

The Graham Expeditionary Middle School  
(Must be completed each year)



Student's name: \_\_\_\_\_ Enrollment Date: \_\_\_\_\_  
Last First Middle  
 Grade: \_\_\_\_\_ Female: \_\_\_ Male: \_\_\_ Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Month/Day/Year

**Medication History:**

Present medications given daily: \_\_\_\_\_  
 Reason: \_\_\_\_\_  
 Past medications given regularly: \_\_\_\_\_  
 Reason: \_\_\_\_\_  
 Additional information: \_\_\_\_\_

**Allergies:** Please describe known allergies below. Indicate severity: mild, moderate, or severe:

Drugs \_\_\_\_\_ Food \_\_\_\_\_ Bees/Wasps \_\_\_\_\_ Animals \_\_\_\_\_ Plants \_\_\_\_\_  
 Pollen \_\_\_\_\_ Dust \_\_\_\_\_ Smoke \_\_\_\_\_ Latex \_\_\_\_\_ Molds \_\_\_\_\_  
 Mildew \_\_\_\_\_ Other \_\_\_\_\_

**Treatment:** Please describe allergy treatment this child currently receives, or has received in the past:

Antihistamines \_\_\_\_\_ Inhalers \_\_\_\_\_  
 Desensitizing shots \_\_\_\_\_ EpiPen required \_\_\_\_\_  
 Other \_\_\_\_\_

**Injuries, Illnesses and Surgeries:** Please list significant history below:

Injuries/Illnesses/Surgeries	Age of Child	Hospitalization Date
1. _____		
2. _____		
3. _____		

**Health History:** Please check any conditions this child has experienced:

<input type="checkbox"/> Acne <input type="checkbox"/> Attention Deficit Disorder <input type="checkbox"/> Anemia <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Congenital abnormalities _____ <input type="checkbox"/> Cancer: Type _____ <input type="checkbox"/> Chickenpox: Date: _____ <input type="checkbox"/> Chronic bowel problems _____ <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Diabetes: Type: _____ <input type="checkbox"/> Depression <input type="checkbox"/> Dermatitis <input type="checkbox"/> Eczema <input type="checkbox"/> Emotional Problems: _____ <input type="checkbox"/> Encephalitis: Date: _____ <input type="checkbox"/> Exposed to cigarette smoke regularly <input type="checkbox"/> Frequent respiratory infections <input type="checkbox"/> Hay fever <input type="checkbox"/> Headaches: Type: _____ <small style="margin-left: 40px;">Treatment: _____</small> <input type="checkbox"/> Heart Disease: Type: _____ <input type="checkbox"/> Hearing loss: _____ <input type="checkbox"/> Hearing aids: _____ <input type="checkbox"/> Hepatitis: Type & Date: _____ <input type="checkbox"/> Hypertension	<input type="checkbox"/> Measles: Date: _____ <input type="checkbox"/> Meningitis: Type & Date: _____ <input type="checkbox"/> Multiple ear infections: Last episode: _____ <small style="margin-left: 40px;">Tubes? ___ Date: _____</small> <input type="checkbox"/> Mumps: Date: _____ <input type="checkbox"/> Near drowning or suffocation: Date: _____ <input type="checkbox"/> Nervous tic: Type: _____ <input type="checkbox"/> Physical handicap _____ <input type="checkbox"/> Poisoning: Date: _____ <input type="checkbox"/> Pregnancy: Date: _____ <input type="checkbox"/> Rheumatic fever: Date: _____ <input type="checkbox"/> Rubella: Date: _____ <input type="checkbox"/> Seizure disorder: Type: _____ <input type="checkbox"/> Sickle cell disease <input type="checkbox"/> Substance abuse: <small style="margin-left: 40px;">___ Tobacco ___ Alcohol ___ Drugs</small> <input type="checkbox"/> Spinal curvature: ___ Scoliosis ___ Kyphosis <input type="checkbox"/> Suicide risk <input type="checkbox"/> Urinary tract problems <input type="checkbox"/> Visual problems <input type="checkbox"/> Wears glasses or contacts: <small style="margin-left: 40px;">Last exam date: _____</small> <input type="checkbox"/> Other _____ _____ _____
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**After delivery:**

Did the baby experience any of the following? If yes, please describe:

Cyanosis (blue skin color): \_\_\_\_\_

Jaundice (yellow skin color): \_\_\_\_\_

Infections: \_\_\_\_\_

Other: \_\_\_\_\_

**Developmental history:** Please Indicate the approximate age that this child:

Walked alone \_\_\_\_\_

Spoke in two-word sentences \_\_\_\_\_

Bowel trained \_\_\_\_\_

Development compared to siblings or playmates:

Bladder trained \_\_\_\_\_

\_\_ Slower \_\_ Faster \_\_ Same

Dressed self \_\_\_\_\_

Other information \_\_\_\_\_

**Sleep Habits or Disturbances:**

How many hours does the child sleep each night? \_\_\_\_\_

Please indicate if the child experiences any difficulties with the following:

\_\_ Mouth breathing \_\_ Snoring \_\_ Sleepwalking \_\_ Bedwetting

**Speech Development:**

Has the child experienced difficulty with speech? \_\_\_\_ Yes \_\_\_\_ No

If yes, please describe: \_\_\_\_\_

Has the child received any speech therapy? \_\_\_\_\_

**Dietary Status:**

Please describe any concerns with the child's nutrition: \_\_\_\_\_

Weight concerns \_\_\_\_\_ Does the child usually eat breakfast? \_\_\_\_\_

Avoid certain foods? \_\_\_\_\_ Other food related concerns: \_\_\_\_\_

**Dental History:**

Name of Dentist: \_\_\_\_\_ Date of last exam: \_\_\_\_\_

Special dental needs or problems: \_\_\_\_\_

**Special Needs:**

Do you have other information or concerns about this child's physical or emotional health, growth and development, behavior, or family circumstances that you feel the school should be aware of?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Completed by:** \_\_\_\_\_

Signature

**Relationship to child:** \_\_\_\_\_ **Date:** \_\_\_\_\_