

MILFORD HEALTH DEPARTMENT

HIGH SCHOOL HISTORY FORM

The following questions are about your health. Please answer them as completely as possible. You may want your parent or guardian to help you.

Name: _____ Birthdate: _____ Sex: Male _____ Female _____
Address: _____ Grade: _____

1. How would you describe your general health?

Excellent Good Fair Poor

2. Do you have any concerns or questions about your

physical development	<input type="checkbox"/> yes <input type="checkbox"/> no	appetite	<input type="checkbox"/> yes <input type="checkbox"/> no
general health or behavior	<input type="checkbox"/> yes <input type="checkbox"/> no	sleeping habits	<input type="checkbox"/> yes <input type="checkbox"/> no
eating too little	<input type="checkbox"/> yes <input type="checkbox"/> no	school progress	<input type="checkbox"/> yes <input type="checkbox"/> no
overeating	<input type="checkbox"/> yes <input type="checkbox"/> no	school marks	<input type="checkbox"/> yes <input type="checkbox"/> no

Do you have any concerns or questions about your relationship with

Family	<input type="checkbox"/> yes <input type="checkbox"/> no	friends outside of school	<input type="checkbox"/> yes <input type="checkbox"/> no
Friends in school	<input type="checkbox"/> yes <input type="checkbox"/> no	girlfriend/boyfriend	<input type="checkbox"/> yes <input type="checkbox"/> no

If yes to any questions, please explain: _____

Do you have any concerns or questions about recent changes in your home/family life (answers to this question are optional and confidential)

Divorce	<input type="checkbox"/> yes <input type="checkbox"/> no	death	<input type="checkbox"/> yes <input type="checkbox"/> no
Step parents	<input type="checkbox"/> yes <input type="checkbox"/> no	parent's girl/boy friend	<input type="checkbox"/> yes <input type="checkbox"/> no
New family members (baby, grandparents, etc.)	<input type="checkbox"/> yes <input type="checkbox"/> no	moving	<input type="checkbox"/> yes <input type="checkbox"/> no

Please indicate if you would like to discuss this with the NURSE yes no

3. Please check if anyone in your family has a problem with:

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Cancer, type _____	<input type="checkbox"/> Mental/emotional illness
<input type="checkbox"/> Bleeding problem	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Allergies/Asthma	<input type="checkbox"/> Stomach/intestinal problem
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Seizures/convulsions
<input type="checkbox"/> Bone/muscle disease	<input type="checkbox"/> Birth defects
<input type="checkbox"/> Anemia/sickle cell anemia	<input type="checkbox"/> Mental retardation
<input type="checkbox"/> Heart disease	<input type="checkbox"/> Growth disorders
<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Other: _____

4. Are your immunizations up-to-date? yes no If no, please explain: _____
Date of last Tetanus booster: _____

5. Do you take any type of medication or vitamins? yes no If yes, please state name of Medicine/vitamin, the amount and the reason you take the medicine: _____

OVER

6. Do you have allergies? yes no What are you allergic to: (food, medicine, bees, etc.) _____

7. Do you have any problems or worries about your

Scalp/skin	<input type="checkbox"/> yes <input type="checkbox"/> no	Head (Headaches, migraines, dizziness, fainting)	<input type="checkbox"/> yes <input type="checkbox"/> no
Eyes/ear	<input type="checkbox"/> yes <input type="checkbox"/> no	Stomach	<input type="checkbox"/> yes <input type="checkbox"/> no
Sinuses	<input type="checkbox"/> yes <input type="checkbox"/> no	Kidneys/bladder	<input type="checkbox"/> yes <input type="checkbox"/> no
Heart	<input type="checkbox"/> yes <input type="checkbox"/> no	Bone/muscles	<input type="checkbox"/> yes <input type="checkbox"/> no
Lungs	<input type="checkbox"/> yes <input type="checkbox"/> no	Joints (knees, elbows)	<input type="checkbox"/> yes <input type="checkbox"/> no
Breasts	<input type="checkbox"/> yes <input type="checkbox"/> no	Menstrual periods	<input type="checkbox"/> yes <input type="checkbox"/> no
		Intestines (frequent loose bowel movements, Constipation)	<input type="checkbox"/> yes <input type="checkbox"/> no

If yes, please explain: _____

Have you ever played sports?	<input type="checkbox"/> yes <input type="checkbox"/> no
Are you involved in a sport now?	<input type="checkbox"/> yes <input type="checkbox"/> no
Have you ever been told you could not play a sport?	<input type="checkbox"/> yes <input type="checkbox"/> no
Have you ever injured a muscle, bone ligament, tendon or joint (sprains, strains, dislocation)?	<input type="checkbox"/> yes <input type="checkbox"/> no
Did you go to the hospital for see a doctor for this injury?	<input type="checkbox"/> yes <input type="checkbox"/> no
Have you ever fainted, passed out or lost consciousness?	<input type="checkbox"/> yes <input type="checkbox"/> no
Are you under medical care?	<input type="checkbox"/> yes <input type="checkbox"/> no
Have you ever had physical therapy?	<input type="checkbox"/> yes <input type="checkbox"/> no
Have you ever had to wear a brace?	<input type="checkbox"/> yes <input type="checkbox"/> no
Have you ever had numbness, tingling, weakness or paralysis with an arm or leg?	<input type="checkbox"/> yes <input type="checkbox"/> no
Have you ever seriously hurt or lost a kidney, eye, ovary, testicle or lung?	<input type="checkbox"/> yes <input type="checkbox"/> no
Do you become short of breath if you run 1/2 mile?	<input type="checkbox"/> yes <input type="checkbox"/> no
Do you exercise on a regular basis (do not count gym class)?	<input type="checkbox"/> yes <input type="checkbox"/> no

If yes to any questions, please explain and give dates: _____

8. PAST HISTORY: **Have you ever had** a learning problem (reading/math) yes no Illness or infection lasting more than one week yes no – Medical problem yes no Behavior problem yes no. **Have you ever been** hospitalized yes no – accident yes no – operated on yes no If yes to any these questions, please explain: _____

Do you wear glasses: yes no contacts yes no Date of last EYE exam: _____

Do you wear braces: yes no Date of last DENTAL exam: _____

Do you have a problem with your hearing? yes no If yes, please explain: _____

DATE

Student Signature

Parent/Guardian Signature