Med Center Health

Student Health Questionnaire

Student's Name ______________________ DOB: ______________

School: ______________________ Date Form Received By the School: ________

Primary Care Provider: ______________________ PCP Phone: ______________

Please list any medications (Over-the-counter and prescription), vitamins, herbs, supplements currently taking or any oils currently using: ______________________

____

____

Please check if the child has a confirmed medical history of any of the following:

CARDIOVASCULAR
- ____ Heart Murmur/Defect
- ____ High Blood Pressure
- ____ Pacemaker
- ____ Life Pack/LVAD Heart Pump

DEVELOPMENTAL/PSYCH
- ____ ADHD/ADD
- ____ Developmental Delays
- ____ Down Syndrome
- ____ Autism
- ____ Mood Problems/Depression

ENDOCRINE
- ____ Heart Murmur/Defect

DIGESTIVE/RECTAL/URINARY
- ____ Frequent Stomach aches
- ____ Acid Reflux
- ____ Wears Diapers
- ____ Incontinence of Stool
- ____ Recurrent Urinary Tract Infections

DIGESTIVE/RECTAL/URINARY
- ____ Inability to void w/o Catheterization
- ____ Kidney Disease
- ____ Incontinence of Urine
- ____ Ostomy
- ____ Urinary Frequency
- ____ Lactose Intolerant
- ____ Constipation Requiring MD Visits
- ____ Inability to eat w/o Tube Feeding

HEAD/EYE/EAR/NOSE/THROAT
- ____ Dental Decay/Problems
- ____ Frequent Sinus Infections
- ____ Frequent Ear Infections
- ____ Hearing Loss or Difficulty
- ____ Vision Loss or Difficulty
- ____ Migraine Headaches
- ____ Head Injury
- ____ Concussion in the past 3 years

HEMATOLOGIC
- ____ Hemophilia
- ____ Sickle Cell Anemia

DIGESTIVE/RECTAL/URINARY
- ____ Inability to void w/o Catheterization

MUSCULOSKELETAL
- ____ Spina Bifida

NEUROLOGICAL
- ____ Neurological Problems
- ____ Cerebral Palsy
- ____ Seizures
- ____ Postural Orthostatic Tachycardia Syndrome (POTS)

PULMONARY
- ____ Cystic Fibrosis

REPRODUCTIVE
- ____ Debilitating Menstrual Cramps

OTHER
- ____ Genetic Disorder
- ____ Immune Deficiency
- ____ Inability to tolerate extreme heat

____ **Other:** ______________________

____ **Asthma** (*If checked, please mark what may bring on this child's asthma)

____ Pollens ____ Animals ____ Illness ____ Weather Changes ____ Smoke ____ Perfume
____ Dust ____ Foods ____ Heat ____ Scents ____ Candles ____ Seasonal Changes
____ Other: ______________________

*What asthma symptoms does this child have? ____ Coughing ___ Shortness of Breath ____ Wheezing
Other symptom______________________

____ Allergic Reaction confirmed by a medical provider to: __ Stinging Insects __ Red Dye __ Latex __ Animals
__ Food(s): ______________________
__ Medication(s): ______________________

*What allergic reaction does this child have? ___ Itching ___ Hives/Rash ___ Wheezing ___ Swelling of Lips, Mouth, Tongue, Throat ___ Nausea/Vomiting/Stomach Cramps ___ Coughing ___ Shortness of Breath ___ Dizziness ___ Unconsciousness ___ Other ______________________

Parent/Guardian completing form signature: ______________________ Date ______ Time ______