

HOWARD COUNTY HEALTH DEPARTMENT SCHOOL BASED WELLNESS CENTER PROGRAM

Medical and Family History Questionnaire

Child's Name: _____	Today's Date: _____
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FAMILY HEALTH INFORMATION

Does any of the child's family members (parents, sisters, brothers, grandparents) have or had the following:

Health Problem	Yes	No	Which Family Member?
Asthma			
Diabetes			
HIV/AIDS			
Mental Health/ Psychiatric Problem			
Sickle Cell			
Tuberculosis/ TB			
Other:			

Allergies (*List all, including medications*) _____

Who is the student's regular health provider?

Name: _____ Office Telephone: () - _____

Address: _____

When was your child's last physical or well child exam? _____
Date/Month

Please provide the name and phone number of your pharmacy.

Name: _____ Phone Number: () - _____

CHILD'S HEALTH INFORMATION

Please place a check in the box for any health problems your child has had.

<input type="checkbox"/> Asthma	<input type="checkbox"/> Attention Deficit Disorder	<input type="checkbox"/> Bleeding Problems	<input type="checkbox"/> Depression
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Ear Infection (frequent)	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Headache (frequent)
<input type="checkbox"/> Hearing	<input type="checkbox"/> Heart Problems/Murmur	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Sickle Cell Anemia
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Vision	<input type="checkbox"/> Other: _____	

If your child has been hospitalized, please provide the date(s) and reason(s):

PLEASE LIST ALL PRESCRIBED AND OVER THE COUNTER MEDICATIONS YOUR CHILD TAKES: _____