Runnemede School District

HEALTH HISTORY QUESTIONNAIRE

This questionnaire will become part of your child's Medical Record - Please fill out completely.

Date: _____ Child's Name: _____ (Last) _____ (Middle) _____ (First)

Sex: M ☐ F ☐ Birth Date: _____ Country of Birth: _____ Grade: _____

Home Address: _____ City _____ State _____ Zip: _____

Tel. No. (Home) _____ Work (Mom) _____ Cell (Mom) _____

Work (Dad) _____ Cell (Dad) _____ Other _____

Primary Care Physician: _____ Primary Care Physician's Number: _____

I. PRENATAL

With this child, were there any problems with:

Your Pregnancy? Yes ☐ No ☐

Labor and delivery? Yes ☐ No ☐

The newborn period? Yes ☐ No ☐

If yes to any of the above, please explain: _____

What was your child's birth weight? _____ lbs. _____ ozs.

II. DEVELOPMENT

Did your child meet his/her developmental milestones at the appropriate time:
(Examples; smile, sit, walk, say words, climb stairs)

Yes ☐ No ☐ If no, please explain: _____

Is your child potty trained (Bowel & Bladder)?

Yes ☐ No ☐ ☐ Uses toilet independently

Comments: _____

Is your Child: ☐ Right Handed ☐ Left Handed

Does your child have any school problems? Yes ☐ No ☐ If yes, please explain: _____

Is your child in a special class? Yes ☐ No ☐ If yes, type of class: _____

III. HEALTH

Is your child allergic to any medication or food? Yes ☐ No ☐ If yes, state medication or food(s):

What happens when he takes it?

Has your child ever had a major illness? Yes ☐ No ☐ If yes, explain including dates:

Has your child had any surgeries? Yes ☐ No ☐ If yes, include dates & reason:

Has your child ever been admitted (overnight)? Yes ☐ No ☐ If yes, list date & reason:

Does your child currently take any daily medications? Please list name, times & reason for medication.

Does your child need any medications during the school day? Yes ☐ No ☐ Name of medications:

Has your child had any of the following (Please check all applicable). Any box checked should be explained in the box below:

Allergies or Hay Fever		Heart Disease		Eat Strange Things (Paint Chips, Newspapers. Etc)	
Asthma or Wheezing		Heart Murmur			
Eczema		Rheumatic Fever			
Food Intolerance		Swollen Joints			
Hives				Blood Problems or Anemia	
Reaction to Bee/ Wasp/ or Insect Sting		Muscle Weakness		Sickle Cell Disease	
		Mental Retardation		Cancer	
Cystic Fibrosis		Cerebral Palsy		Bone Problems/Orthopedic	
Recurrent Pneumonia		Seizures or Convulsions		Abnormal Bleeding	
		Recurrent Headaches		Diabetes	
Celiac Disease Crohn's or Inflammatory Bowel Disease		Lyme's Disease			
Chronic Constipation				Adaptive Aids: wheelchair, braces, glasses, hearing aids, etc.	
Chronic Diarrhea		Chicken Pox		Difficulty seeing	
		Measles		Crossed Eyes	
Repeated Stomach Aches		Tuberculosis		Difficulty hearing	
Bed Wetting/Incontinence				Hearing Loss	
Kidney Disease				Recurrent Ear Infection	
Urinary Infection		Mononucleosis		Speech Problems	
Urinary Reflux		Strep Throat (Last?)			
Hepatitis		Fifth's Disease			
Vaginal Bleeding					

Explanation:

IV. EMOTIONAL DEVELOPMENT

Does your child have (Please check all applicable):

Temper Tantrums		Excessive Quietness		Excessive or Unusual Eating	
Behavior Problems in School		Depression		Lack of Appetite	
Excessive Distractibility		Lack of Friends			
Frequent Fights		Day Dreaming			
Trouble with Police		Frequent Accidents		Insomnia	
		Soiling Self		Unreasonable Fears (Dark/Loud Noises)	
		Bites Nails			
		Sucks on Fingers			

Has your child seen a therapist or guidance counselor in the past for any of the problems checked above?

_____

What is your childs bedtime? _____

Does your child get along with his or her peers? Yes ☐ No ☐ If no, please explain: _____

_____

Would you consider your child: ☐ Quiet & reserved ☐ Sometimes quiet

Would you consider your child: ☐ Sometimes active ☐ Almost always active

V. FAMILY

Does anyone in you or your spouse's family have any of the following (Please check):

Cystic Fibrosis		Arthritis		Kidney Disease	
Anemia		Deafness		Cancer	
Sickle Cell Disease		Early Blindness		Muscular Dystrophy	
Asthma		Convulsions		Scoliosis	
Hay Fever		Mental Retardation		Died Young	
Diabetes		Mental Illness			
Heart Disease (Under 60 years of age)		Server Depression		Hormone (e.g., Thyroid Problem)	
High Blood Pressure		Learning Problems			

Other? Explain: _____

_____

What is the ethnic background of the child's father? _____

What is the ethnic background of the child's mother? _____

VI. SOCIAL

Please respond to the following in relation to your child:

Number of people staying at home? _____

Sibling's Name	Age	School Attending	Special Needs?

VI. SOCIAL (Continued)

Do both parents stay in the same house? Yes ☐ No ☐

If no, with whom does the child live? _____

_____

How many other people sleep in the child's room? _____

Does anyone in the house smoke? Yes ☐ No ☐

Are there any other problems that we should know about regarding your child's health? Is there any information that you think would assist us in planning an educational program for your child?

_____

_____

_____

_____

_____

Parent Signature: _____ **Date:** _____