

**PAST HEALTH HISTORY
 (To be completed by parent)**

NAME _____ Birth Date _____ Sex _____ Grade _____

ADDRESS _____ Telephone _____

Number of Children in Family _____ Name of Family Doctor _____ Name of Family Dentist _____

(Use the reverse side of this record as needed for additional notations.)

A. GENERAL HEALTH

1. Eye symptoms _____
 Wears Glasses _____
 Age when received glasses _____
 Preferential seating needed _____
2. Ear symptoms _____
 Hearing loss _____
 Earaches (explain) _____
 Discharging ear _____
 Preferential seating needed _____
3. Colds, sore throat, etc. _____
4. High fever (Explain) _____
5. Fainting spells (explain) _____
6. Convulsions (Date and cause) _____
7. Dental Problems _____
8. Speech Difficulty _____
9. Medications (Names) _____
 Are they taken regularly? _____
 When? _____
10. Diabetes _____
 Blood Sugar Check _____
 Is there Diabetes in the family? _____
 Give relationship _____
11. Tuberculosis contacts (Who?) _____
 When? _____

E. DISEASE AND CONDITIONS (DATE)

- | | (Date) |
|------------------------|--------|
| Whooping Cough | _____ |
| Chicken Pox | _____ |
| Measles - Rubella | _____ |
| Rubella (3 day) | _____ |
| Mumps | _____ |
| Scarlet Fever | _____ |
| Strep Throat | _____ |
| Rheumatic Fever | _____ |
| Mononucleosis | _____ |
| Polio myelitis | _____ |
| Bronchitis | _____ |
| Pneumonia | _____ |
| Hepatitis | _____ |
| Osgood-Schlatter | _____ |
| Epilepsy | _____ |
| Nose Bleeds (frequent) | _____ |
| Asthma | _____ |
| Eczema | _____ |
| Meningitis | _____ |
| Other | _____ |
| | _____ |
| | _____ |
| | _____ |

B. OPERATIONS (Type of surgery and dates) _____

C. INJURIES(Explanation and dates) _____

D. OTHER _____

Is there any condition present which should be considered in planning your child's program at school? _____

 (Date)

 (Signature of parent or guardian)