Revised 12/30/14

Hamden Public Schools
Hamden School Health Services
Health History Questionnaire

Revised 8/27/12

Dear Parent/Guardian,

Please fill out the following health history information if your child is a new entrant to Hamden elementary schools and return to the school nurse. If this is part of the kindergarten packet, please bring the completed form to the school nurse when your register for school along with your child's Immunization records.

1. Identifying Information

Student's Name: _____ Entering Grade: _____ Email: _____

Current Address: _____ Phone:_____ Cell: _____
(Include Apartment/Floor)

Date of Birth: _____ Birth Place:_____ Gender: ☐ Male ☐ Female☐ Non-Binary

Parent/Guardian Name(s): _____

Last School Attended:_____

2. Early Health and Developmental History

Birth Weight: _____
Please note any complications of pregnancy, labor or delivery, such as illness, infection, long labor, prematurity, etc.:_____

_____

_____

Have you or your primary health care provider identified any developmental problems or concerns?
☐ Yes ☐ No
If yes, please explain:

_____

_____

3. Medical Information

Primary Health Care Provider's Name: _____ Phone:_____

Date of last physical exam_____

Findings:_____

_____

Is your child on regular medication? ☐ Yes ☐ No If yes, please name and explain:

_____

_____

Does your child occasionally need medication for any reason? ☐ Yes ☐ No If yes, please name and explain:

_____

_____

Does your child have an allergy to:

Food	☐Yes	☐No	☐ If yes, explain:_____
Insects	☐Yes	☐No	☐ If yes, explain:_____
Medication	☐Yes	☐No	☐ If yes, explain:_____

Latex ☐Yes ☐No ☐ If yes, explain:_____
Other ☐Yes ☐No ☐ If yes, explain:_____

4. Review of Systems

If your child has/had any of the following within the past 12 months please check and briefly describe.

Head: ☐None/No incidents ☐ Loss of Consciousness ☐ Pain

Eyes: ☐None/No incidents ☐ Squinting ☐ Tearing ☐ Cross Eyes ☐ Loss/Impaired Sight

Ears: ☐None/No incidents ☐ Excess Wax ☐ Frequent Infections ☐ PE Tubes ☐ Loss/Impaired Hearing

Nose: ☐None/No incidents ☐ Frequent Colds ☐ Nose Bleeds ☐ Allergies (explain type)

Throat: ☐None/No incidents ☐ Frequent Infections ☐ Strep Throat ☐ Difficulty Swallowing

Mouth &Teeth: ☐None/No incidents ☐ Toothaches ☐ Cavities ☐ Sourness of the Mouth ☐ Speech Problems

Lungs: ☐None/No incidents ☐ Difficulty Breathing ☐ Wheezing ☐ Persistent Cough ☐ Asthma ☐ Infections (Bronchitis/Pneumonia)

Heart: ☐None/No incidents ☐ Murmur ☐ Chest Pains ☐ Tires Easily ☐ Shortness of Breath ☐ High Blood Pressure ☐ Elevated Heart Rate

Stomach & Bowels: ☐None/No incidents ☐ Vomiting ☐ Diarrhea ☐Constipation ☐ Frequent Stomachaches

Bladder & Kidneys: ☐None/No incidents ☐ Painful Urination ☐ Infections ☐Bed Wetting

Bones & Muscles: ☐None/No incidents ☐ Joint Pain ☐ Joint Swelling ☐ Limp ☐ Knee Pain

Growth: ☐None/No incidents ☐ Overweight ☐ Underweight ☐Anemia (low red blood cells) ☐ Too short ☐ Too Tall

Skin & Lymph: ☐None/No incidents ☐ Rashes ☐ Hives ☐Infections ☐ Swollen Glands ☐ Bruise Easily ☐ Eczema

Hospitalization (explain): _____

Serious Injury/Accident (explain): _____

Surgery (explain): _____

5. Current Behavior and Development
Activities of daily living: Please briefly describe:

Usual sleep pattern (include any problem): _____

_____

Usual eating pattern (include any dietary limitations): _____

_____

Elimination Pattern (indicate any problem with urination or bowel movement): _____

_____

Exercise Habits: _____

Behaviors Please check and explain as appropriate. My child...

is overly active	☐Yes	☐No	☐Sometimes:_____
is easily distracted	☐Yes	☐No	☐Sometimes:_____
is very quiet	☐Yes	☐No	☐Sometimes:_____
has unusual fears	☐Yes	☐No	☐Sometimes:_____
has temper tantrums	☐Yes	☐No	☐Sometimes:_____
plays regularly with other children	☐Yes	☐No	☐Sometimes:_____
can cooperate with other children	☐Yes	☐No	☐Sometimes:_____

Skills Can your child use...

pencils?	☐Yes	☐No
crayons?	☐Yes	☐No
scissors?	☐Yes	☐No

Language

Can strangers easily understand your child's speech?	☐Yes	☐No
Is your child under care for speech?	☐Yes	☐No

What languages are spoken at home? _____

6. Family Information
Has your family had any recent significant changes? (death, divorce, move)
If yes, please explain:

_____

_____

Does any immediate family member or relative have any significant medical problem(s)?
If yes, please explain:

_____

_____

Please provide the following information for other children in your family:

Name	Age	Gender	Any Health Problems?	School (if still in school)

Medical Insurance: _____

(please list insurance company)

7. Health History

If your child has had one of the following health problems, please check the appropriate age(s) and provide details

Type of Health Problem (Please Check)	Unsure	Never	0-6 Months	7-12 Months	13-18 Months	19-24 Months	2 years	3 years	4 years	5-7 years	8-12 years	Explain (please use back of page to provide more information)
Skin Problem – Rash												
Headache/Migraine												
High Fever(s) –Over 103°												
Loss of Consciousness												
Meningitis												
Seizures/Spells												
Tic/Tremors												
Eye Problems												
Wears Glasses/Contacts												
Allergies												
Ear Problem-Chronic												
Cleft lip or palate												
Asthma												
Pneumonia/bronchitis												
Heart or Blood problem												
Stomach or Intestinal problem												
Diarrhea –Chronic												
Constipation- Chronic												
Intestinal Parasite												
Type of Health Problem (Please Check)	**Unsure**	**Never**	**0-6 Months**	**7-12 Months**	**13-18 Months**	**19-24 Months**	**2 years**	**3 years**	**4 years**	**5-7 years**	**8-12 years**	**Explain (please use back of page to provide more information)**
Nutritional Problem												
Overweight/ Underweight												
Urinary or genital tract problem												
Arthritis												
Fractures												
Musculoskeletal Problems/deformity												
Diabetes												
Growth Problems												
Thyroid Problem												
Depression												
Suicidal Gesture												

Type of Health Problem (Please Check)	Unsure	Never	0-6 Months	7-12 Months	13-18 Months	19-24 Months	2 years	3 years	4 years	5-7 years	8-12 years	Explain (please use back of page to provide more information)
Ear Problem/Infection												
Anemia (low blood count)												
Cancer/Leukemia												
Other Serious Condition												
Surgery												
Lead Poisoning												
Serious Injury/Accident												
Hospitalization												

8. School Adjustment

How do you think your child will react on the first day of school?

_____

_____

Is there anything we can do or should know that might help your child in adjusting positively in school?

_____

_____

What does your child enjoy?_____

_____

Please list your child's interests:_____

_____

What does your child dislike?

_____

_____

Thank you for your time and assistance. This information will help me to provide appropriate health care for your child in the school setting. Please keep me updated about any future changes in your child's health status.

I can be reached at: _____
Sincerely,

_____ _____
School Nurse Date

The above information is accurate to the best of my knowledge:

_____ _____
Parent/Guardian Signature Date