Mercy Health – Little Miami School Health Center
Child Health History

Name of Child _____Date of Birth _____

Please provide the following information, which will help us provide health care to your child. All information will be kept confidential, in accordance with the HIPAA privacy rule.

List Allergies to medications, foods or other things:

_____

Has your child had any operations, hospitalizations, or serious accidents? YES NO
If **YES**, please provide description, dates _____
_____

Did any of the following affect your child? *(please check all that apply)*
___ Problems during pregnancy or delivery
___ Exposure to drugs or alcohol during pregnancy
___ Prematurity
___ Slow development in infancy

Has your child had any of the following illnesses or conditions?
(Please check all that apply and **indicate dates**)

Eyes

	Wears glasses
	Lazy eye
	Pink eye

Ears/Nose/Lungs

	Asthma
	Tuberculosis
	Allergies
	Ear infections
	Strep throat
	Hearing loss
	Household smoking
	Nosebleeds

Mouth/Stomach

	Weighs too much or little
	Frequent stomachaches
	Constipation
	Ulcer
	Diarrhea
	Dental cavities
	Diabetes

Heart

	Heart murmur
	High blood pressure

Skin

	Eczema (very dry skin)
	Rash

Brain/Neurological

	Learning problem
	Behavior problem
	ADHD
	Seizures
	Headaches
	Depression
	Sleep problem
	Speech problem

Bone/Muscle

	Broken bone(s)
	Problems walking

Blood

	Anemia
	Elevated lead level

Does your child take any daily prescribed medications? YES NO
If **YES**, please list _____

Does your child take any over-the-counter medications regularly? YES NO
If **YES**, please list _____

Is your child up to date on immunizations? YES NO DON'T KNOW

(Health History, continued)

Has your child received counseling for any reason? YES NO
If **YES**, when and where? _____

Who is your child's regular doctor? _____

Has your child's doctor recommended any restrictions of activity for your child?
YES NO If **YES**, please list restrictions _____

Would you like your child to have his/her annual well child visit here at the school based health center? YES NO

Family Medical History (please check all that apply)

	Cancer		Diabetes		Heart disease
	Asthma		Allergies		Seizures
	Obesity		Learning disabilities		Mental health problems
	Tobacco use		Alcoholism		Mental retardation
	Stroke		Depression		ADHD
	Migraines		High blood pressure		
	Sudden death related to heart problems in a family member before the age of 50				

Please list all persons living in child's home and relationship to child

_____

_____

_____

_____

Signature of Parent/Guardian _____

Date _____