

## Interval Health History

Child's Name \_\_\_\_\_ Grade \_\_\_\_\_ Date \_\_\_\_\_

In order to keep your child's health record up to date and to provide better health services for your child, we ask that you complete the following health history and return it to the school nurse. Use the reverse side for detailed information.

Date of last physical examination: \_\_\_\_\_ Physician's Name: \_\_\_\_\_

Date of last dental examination: \_\_\_\_\_ Dentist's Name: \_\_\_\_\_

**Does your child have a history of:**

Allergic reactions: \_\_\_\_\_

Asthma: \_\_\_\_\_

Other respiratory infections: \_\_\_\_\_

Bone or joint disease: \_\_\_\_\_

Communicable diseases: \_\_\_\_\_

Convulsions-seizures: \_\_\_\_\_

Dental problems: \_\_\_\_\_

Diabetes: \_\_\_\_\_

Ear Infections: \_\_\_\_\_

Frequent headaches: \_\_\_\_\_

Heart condition: \_\_\_\_\_

Kidney problems: \_\_\_\_\_

Nosebleeds: \_\_\_\_\_

Skin problems: \_\_\_\_\_

Stoamch-GI-problems: \_\_\_\_\_

Throat infections: \_\_\_\_\_

**Has your child had any: (Give details – dates)**

Operations: \_\_\_\_\_

Serious accidents: \_\_\_\_\_

Fractured bones: \_\_\_\_\_

Serious head injuries: \_\_\_\_\_

Hospitalizations: \_\_\_\_\_

**Does your child:**

Have any dietary restrictions: \_\_\_\_\_

Wear eyeglasses: \_\_\_\_\_

Have a hearing aid: \_\_\_\_\_

Use crutches: \_\_\_\_\_

Wear an orthopedic device: \_\_\_\_\_

Have any orthodontic appliances in place: \_\_\_\_\_

What Medications(s), if any, does your child take: \_\_\_\_\_

Please add any other concerns that you might have: \_\_\_\_\_

\_\_\_\_\_  
Signature