Heartland Health Centers
School-Based Health History Form

Patient's Name: _____ **Date of Birth:** __ / __ / _____

Medical History:

Has your child ever been hospitalized? .....**Yes No**
If Yes, please explain (including dates and reasons for hospitalization):
_____

Has your child had any operations or surgeries? .....**Yes No**
If Yes, please explain (including dates and reasons for surgery):
_____

Does your child take medications? .....**Yes No**
If Yes, please list them:
_____

Has your child had any serious injuries? .....**Yes No**
If Yes, please explain:
_____

Does your child have any allergies to medications? .....**Yes No**
If Yes, please list them:
_____

Does your child have any allergies to food(s)? .....**Yes No**
If Yes, please list them:
_____

Does your child have a bleeding problem/Does your child bleed or bruise easily? .....**Yes No**
If Yes, please explain:
_____

Dental History:

Have you noticed any of the following changes in your child's teeth/mouth? **(Check all that apply)**
____Discoloration ____Bleeding Gums ____Ulcerations (wounds) ____Infection ____Pain

Who brushes the child's teeth? **(Check all that apply)**
____Child ____Caregiver ____Parent ____Sibling

Family Medical History: Does anyone in your family (parent, sibling, grandparent, aunt/uncle) have any of the following health conditions? **(Check all that apply)**

	Asthma		Bleeding Problem		High Blood Pressure		Heart Disease/Attack		Sudden Death
	Anemia		Cancer		Diabetes		Seizures/Epilepsy		Depression
	Emotional Disorder		Migraine		High Cholesterol		Sickle Cell Disease		TB/Positive PPD Test

List any concerns that you have about your child's physical or mental health that you would like us to investigate or treat at the school-based health center:

_____

_____ _____
Parent/Guardian Name (Print) Date

_____
Parent/Guardian Signature