

Today's Date: \_\_\_\_\_

## Interval Health History

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

1. Has your child ever been in the hospital or had an operation?( if yes, explain) \_\_\_\_\_  
\_\_\_\_\_
2. Has your child ever been in an accident? \_\_\_\_\_  
\_\_\_\_\_
3. Allergic reactions (to food, bee stings, medications, latex or other allergens): YES / NO  
Please list specifically and describe reaction: \_\_\_\_\_  
\_\_\_\_\_
- Does child have an Epi-Pen? (please circle) Yes / No
4. Asthma: YES / NO Asthma triggers: \_\_\_\_\_  
Treatment: Nebulizer / Inhaler \_\_\_\_\_
5. Other respiratory infections/conditions? \_\_\_\_\_
6. Bone/Joint diseases or injuries: (explain) \_\_\_\_\_
7. Convulsions/Seizures (explain): \_\_\_\_\_
8. Diabetes: YES / NO Treatment: \_\_\_\_\_
9. Dental Problems: \_\_\_\_\_
10. Ear Infections/hearing trouble: \_\_\_\_\_ Tubes? YES / NO
11. Frequent Headaches: \_\_\_\_\_ Treatment: \_\_\_\_\_
12. Heart Problems (explain): \_\_\_\_\_  
Treatment: \_\_\_\_\_
13. Kidney Trouble (explain): \_\_\_\_\_
14. Any other illnesses not mentioned above (explain) \_\_\_\_\_
15. Does your child have any eye trouble or vision problems? YES / NO Year of last exam? \_\_\_\_\_  
Do they wear glasses/contact lenses? YES/ NO For: NEAR DISTANCE
16. Does your child take any medication at home prescription **or** over the counter? YES NO  
Medication: \_\_\_\_\_  
Reason for medication: \_\_\_\_\_
17. Physical limitations or restrictions (**DOCUMENTED BY DOCTOR**) \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature