**HEALTH DEPARTMENT-NURSING DIVISION**
EVANSVILLE, INDIANA

Allergies: _____
_____

## PAST HEALTH HISTORY
(To be completed by parent)

NAME _____ BIRTH DATE _____ SEX _____ GRADE _____
Last First Middle Month-Day-Year M/F

ADDRESS _____ TELEPHONE _____

Number of Children in Family ____ Name of Family Doctor_____ Name of Family Dentist_____

(Use the reverse side of this record as needed for additional notations.)

A. GENERAL HEALTH

1. Eye symptoms _____
   Wears Glasses _____
   Age when received glasses _____
2. Ear Symptoms _____
   Hearing _____
   Earaches (Explain) _____
   Discharging ear _____
3. Colds, sore throat, etc. _____
4. High fever (Explain) _____
5. Fainting spells (Explain) _____
6. Convulsions (Date and cause) _____
7. Dental problems _____
8. Speech difficulty _____
9. Nervous habits _____
   Temper tantrums _____ Bed wetting _____
   Thumbsucking_____ Nailbiting _____
   Other _____ Cries easily _____
10. Medication (Name) _____
    Are they taken regularly? _____
    When? _____
11. Diabetes _____
    Is there diabetes in family? _____
    Give relationship _____
12. Tuberculosis contacts (Who?) _____
    When? _____

B. OPERATIONS (Explanation and dates) _____
_____

C. INJURIES (Explanation and dates) _____
_____

D. OTHER: _____
_____

E. DISEASES AND CONDITIONS

| | (Date) |
|---|---|
| Whooping Cough | _____ |
| Chickenpox | _____ |
| Measles - Rubella | _____ |
| Rubella (3 day) | _____ |
| Mumps | _____ |
| Scarlet Fever | _____ |
| Strep Throat | _____ |
| Rheumatic Fever | _____ |
| Mononucleosis | _____ |
| Poliomyelitis | _____ |
| Bronchitis | _____ |
| Pneumonia | _____ |
| Hepatitis | _____ |
| Osgood-Schlatter | _____ |
| Epilepsy | _____ |
| Nose Bleeds | _____ |
| Asthma | _____ |
| Eczema | _____ |
| Allergies (Specify) | _____ |
| _____ | |
| _____ | |

F. GROWTH AND DEVELOPMENT

Normal Birth? Yes ___ No ___
If not, explain _____

Age of:

| | |
|---|---|
| First tooth | _____ months |
| Sitting | _____ months |
| Walking | _____ months |
| First words | _____ months |
| Sentences | _____ months |
| Toilet trained | _____ months |

Is there any conditions present which should be considered in planning your child's program at school?
_____

_____ _____
DATE Signature of parent or guardian

PLEASE RETURN TO THE SCHOOL HEALTH CHAIRMAN

5/06