**HOWARD COUNTY HEALTH DEPARTMENT**

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**SCHOOL BASED WELLNESS CENTER PROGRAM**

**Medical and Family History Questionnaire**

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| --- | --- |
| **Child’s Name:** | **Today’s Date:** |
| **FAMILY HEALTH INFORMATION****Does any of the child’s family members (parents, sisters, brothers, grandparents)have or had the following:** |
| **Health Problem** | **Yes** | **No** | **Which Family Member?** |
| **Asthma** |  |  |  |
| **Diabetes** |  |  |  |
| **HIV/AIDS** |  |  |  |
| **Mental Health/ Psychiatric Problem** |  |  |  |
| **Sickle Cell** |  |  |  |
| **Tuberculosis/ TB** |  |  |  |
| **Other:** |  |  |  |
| **Allergies (*List all, including medications*)** |
| **Who is the student’s regular health provider?****Name: Office Telephone:** ( ) **-****Address:** **When was your child’s last physical or well child exam?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date/Month****Please provide the name and phone number of your pharmacy.****Name: Phone Number:** ( ) **-****CHILD’S HEALTH INFORMATION****Please place a check in the box for any health problems your child has had.** **Asthma Attention Deficit Disorder Bleeding Problems Depression** **Diabetes Ear Infection** (frequent) **Epilepsy/Seizures Headache** (frequent) **Hearing Heart Problems/Murmur Rheumatic Fever Sickle Cell Anemia** **Tuberculosis Vision Other:** **If your child has been hospitalized, please provide the date(s) and reason(s):** |

**PLEASE LIST ALL PRESCRIBED AND OVER THE COUNTER MEDICATIONS YOUR CHILD TAKES:**

**HCHD 6.26.15**