**HOWARD COUNTY HEALTH DEPARTMENT**

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**SCHOOL BASED WELLNESS CENTER PROGRAM**

**Medical and Family History Questionnaire**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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**