HOWARD COUNTY HEALTH DEPARTMENT
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: _____

_____