URBANA SCHOOL DISTRICT #116
205 N. RACE STREET; P.O. BOX 3039
URBANA, IL 61803-3039

HEALTH HISTORY

Student's Name_____ **Date of Birth** _____
School_____ **Grade Level**_____
Parent Signature_____ **Date**_____

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Allergies (Food, Drug, Insect, Other) _____

Medication (List all prescribed or taken on a regular basis) _____

	Circle One		Comments
Diagnosis of Asthma?	Yes	No	
Child wakes during night coughing?	Yes	No	
Birth Defects?	Yes	No	
Developmental Delay?	Yes	No	
Blood Disorders? Hemophilia, Sickle Cell, Other? Explain	Yes	No	
Diabetes?	Yes	No	
Head Injury/Concussion/Passed Out?	Yes	No	
Seizures? If yes, what are they like?	Yes	No	
Heart Problem/Shortness of breath?	Yes	No	
Heart Murmur/High blood pressure?	Yes	No	
Dizziness or chest pain with exercise?	Yes	No	
Eye/Vision Problems?	Yes	No	
Glasses ?	Yes	No	
Contacts?	Yes	No	
Last exam by eye doctor? If yes, when?	Yes	No	
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)	Yes	No	
Ear/Hearing problems?	Yes	No	
Bone/Joint problem/injury/scoliosis?	Yes	No	
Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No	
Hospitalizations? If yes, when and what for?	Yes	No	
Surgery? If yes, when and what for?	Yes	No	
Serious injury or illness? If yes, for what?	Yes	No	
TB skin test positive (past/present)?	Yes	No	
TB disease (past/present)?	Yes	No	
Tobacco use (type, frequency)?	Yes	No	
Alcohol/Drug Use?	Yes	No	
Family history of sudden death before age 50? If yes, cause?	Yes	No	
Dental Braces, Bridge, Plate, or Other? If yes, specify.	Yes	No	