Wellness Center
Health/Family History Questionnaire

(To be completed by Parent/Guardian)

Student Name:	Date of Birth:	Sex: (circle) Male Female
Form Completed By:	Relationship:	Today's Date:

PREGNANCY AND BIRTH HISTORY

Illnesses/medications during pregnancy?
No ☐ Yes ☐
Alcohol/Drug/Alcohol use? No ☐ Yes ☐
Problems at birth? No ☐ Yes ☐
Describe: _____
Did child stay in intensive care nursery after birth?
No ☐ Yes ☐ Why?_____
Type of delivery? ☐ Vaginal ☐ C-section
If C-Section, why _____

PSYCHOSOCIAL HISTORY

Who lives in household? ☐Mother ☐Father
☐ Siblings ☐ Grandparent/s ☐ Other children
☐ Other adults How many?_____
☐ Rent? ☐ Own? ☐ Shelter?
Who cares for child during the day?_____
_____
Are parents working? Mother No ☐ Yes ☐
Father No ☐ Yes ☐
Foster Care? _____ Dates:_____
Other Languages?_____

FAMILY HISTORY

Has anyone in the family (parents, grand-parents, aunts/uncles, sisters/brothers) had:

	Yes	No	Who?
Allergies (List) _____	☐	☐	_____
Asthma	☐	☐	_____
TB/Lung Disease	☐	☐	_____
HIV/AIDS	☐	☐	_____
Suicide Attempts	☐	☐	_____
Heart Disease	☐	☐	_____
High Blood Pressure/Stroke	☐	☐	_____
High Cholesterol	☐	☐	_____
Blood Disorders/Sickle Cell	☐	☐	_____
Diabetes	☐	☐	_____
Seizures	☐	☐	_____
Mental Illness/depression	☐	☐	_____
Cancer	☐	☐	_____
Birth Defects	☐	☐	_____
Hearing Loss	☐	☐	_____
Speech Problems	☐	☐	_____
Kidney Disease	☐	☐	_____
Alcohol/Drug Abuse	☐	☐	_____
Hepatitis/Liver Disease	☐	☐	_____
Thyroid Disease	☐	☐	_____
Learning Problems/Attention Deficit Disorder	☐	☐	_____
Family Violence	☐	☐	_____
Any other family health history concerns: _____ _____	☐	☐	_____

YOUR CHILD'S MEDICAL HISTORY

Has your child ever had:

Allergies (eg. Medications)	Yes	No	Comments
List_____	☐	☐	
Asthma	☐	☐	_____
Chicken Pox (Month/Year) __	☐	☐	_____
Frequent Ear Infections	☐	☐	_____
Vision/Hearing Problems	☐	☐	_____
Skin Problems/Eczema	☐	☐	_____
TB/Lung Disease	☐	☐	_____
Seizures/Epilepsy	☐	☐	_____
CP/meningitis	☐	☐	_____
High Blood Pressure	☐	☐	_____
Heart Defects/Disease	☐	☐	_____
Liver Disease/Hepatitis	☐	☐	_____
Diabetes	☐	☐	_____
Kidney Disease/Bladder Infections	☐	☐	_____
Speech or Learning Disabilities	☐	☐	_____
Physical limitations	☐	☐	_____
Bleeding Disorders/Hemophilia	☐	☐	_____
Sexually Transmitted Infections	☐	☐	_____
Emotional or Behavioral Problems	☐	☐	_____
Depression/Suicidal Thoughts	☐	☐	_____
Hospitalizations/Surgeries	☐	☐	_____
Physical/Emotional/ Sexual Abuse	☐	☐	_____
Bone or Joint Injuries	☐	☐	_____
Obesity/Eating Disorders	☐	☐	_____
Other: _____ _____	☐	☐	_____

Current Medication(s): (*List*) _____
_____

Reviewed by:	Date of Review: