NORTH PENN SCHOOL DISTRICT **#10**
LANSDALE, PA 19446

ELEMENTARY STUDENT HEALTH HISTORY

STUDENT'S NAME _____ **DATE** _____

A. PREGNANCY AND BIRTH (Check Answer)

1. Was the mother's pregnancy accompanied by any special problems (required medications, exposed to toxic substances, etc.)? No ___Yes ___
   _____
2. Was the baby carried full term? No ___Yes ___
3. Was the birth accompanied with any difficulties? _____ No ___Yes ___
   _____
4. What was the baby's birth weight? _____
5. Did the baby have any trouble following birth (require oxygen, incubator, extended stay, etc.)? _____ No ___Yes ___

B. EARLY CHILDHOOD HISTORY

1. Would you describe the baby as average, quiet, or active? _____
2. Did the baby have any special problems in the first six months?
   _____ No ___Yes ___
3. At what age did the child sit alone without support? _____
4. Did the child crawl? No ___Yes ___
5. At what age did the child walk alone without support? _____
6. At what age did the child begin to say two or three words together? _____
7. If the child has stopped wetting the bed, at what age did he or she stop? _____

C. HEALTH HISTORY

1. Has the child ever been in a hospital or had an operation? No ___Yes ___
   When? What for? Name of hospital
   _____
   _____
2. Does the child have a history of hypoglycemia, diabetes, bronchitis, pneumonia, or any other illness? No ___Yes ___
   Onset: _____
   _____
3. Has the child ever had any serious accidents or broken bones? No ___Yes ___
   When? What was the problem? _____
   _____
4. Is the child taking any medicines or vitamins now? What for? No ___Yes ___
   _____

D. ANSWER THE FOLLOWING QUESTIONS:

1. Has the child ever had chicken pox? If yes, date _____ 1. No ___Yes ___
2. Has the child ever had scarlet fever? 2. No ___Yes ___
3. Has the child had more that six colds or throat infections accompanied by a fever within a year? 3. No ___Yes ___

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D. ANSWER THE FOLLOWING QUESTIONS (continued): **(Check Answer)**

4. Has the child had any trouble with ears or hearing? 4. No ___Yes ___
5. Has the child had any trouble with eyes or seeing? 5. No ___Yes ___
6. Has the child ever had any trouble with teeth? 6. No ___Yes ___
7. Has the child ever had a convulsion or fit? 7. No ___Yes ___
8. Has the child ever had a fainting spell: 8. No ___Yes ___
9. Has the child ever had a head injury? 9. No ___Yes ___
10. Has the child ever been unconscious? 10. No ___Yes ___
11. Does the child complain of headaches? 11. No ___Yes ___
12. Has a doctor ever said the child had a heart murmur? 12. No ___Yes ___
13. Does the child become tired easily? 13. No ___Yes ___
14. Do any foods disagree with the child? 14. No ___Yes ___
15. Does the child often have diarrhea? 15. No ___Yes ___
16. Has constipation ever been much of a problem for your child? 16. No ___Yes ___
17. Does the child complain of bellyaches? 17. No ___Yes ___
18. Does the child have any problem with urination? 18. No ___Yes ___
19. Does the child have any skin problems? 19. No ___Yes ___
20. Has the child ever had eczema or allergy? 20. No ___Yes ___
21. Has the child ever had asthma or wheezing? 21. No ___Yes ___
22. Has the child ever had an allergy or reaction to any medicines or injections? 22. No ___Yes ___
    What was the medicine or injection? _____
23. a) Does your child have an insect allergy? 23 (a). No ___Yes ___
    b) Is medication required? 23 (b). No ___Yes ___
24. a) Is your child currently receiving speech/language services? 24 (a). No ___Yes ___
    If "Yes" state where services are provided. _____
    b) Has your child previously been seen by a Speech/Language Pathologist? 24 (b). No ___Yes ___
    If "Yes" please explain: _____
    _____
25. Is your child's speech easily understood by others? 25. No ___Yes ___
    If not, check areas of difficulty: ____ ARTICULATION (sounds)
    ____ LANGUAGE (sentence patterns, vocabulary use, ability to understand directions, commands, ability to hold a conversation) ____ VOICE
    ____ FLUENCY (stuttering)

COMMENTS TO ANSWERS:

_____
_____
_____
_____
_____
_____