

Confidential Health History Review

Student Name:	Birthda	te:	Grade:	
Parent/Guardian Name:	Daytim	Daytime Phone:		
Parent/Guardian Name:		e Phone:		
	T = .			
Health Care Provider:	Phone:		Last Visit:	
Dentist:	Phone:		Last Visit:	
Psychiatrist:	Phone:		Last Visit:	
Counselor/Therapist:	Phone:		Last Visit:	
Dlos	aca dacariba any avictina			
	se describe any existing	g conditions:		
Allergies (e.g.: food, medication, env	ronment)			
ADD/ADUD (attention deficit (byne	maativity) digandan)			
ADD/ADHD (attention deficit (hype	ractivity) disorder)			
Mental Health (e.g.: depression, anx	ioty OCD appositions	dofiont disorder bir	olor dicordor)	
Wientai Health (e.g., depression, and	nety, OCD, oppositiona	i denant disorder, dif	Joiai uisoiuei)	
Other Health Conditions (e.g.: diabo	etes autism seizures/en	ilensy headaches To	urette's)	
Other Treath Conditions (e.g., diabo	ces, autisiii, seizures/ep	nepsy, neadacties, 10	dictic s)	
Vision Concerns (past/present)				
Qq				
Wears lenses for: Distance	Reading Astigmati	sm Other		
Hearing Concerns (past/present)				
PE Tubes: Yes No	Hearing Issues: Yes	s No		
Activity Restrictions (if yes, please explain)				

Please list the names of the	he medications taken	at	
Home			
-			
School			
School			
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Dogant or Significant Ho	amitalinations		
Recent of Significant 110	spitanzations		
	Reason	Hospital Name	Time Period
		Hospital Name	Time Period
		Hospital Name	Time Period
		Hospital Name	Time Period
		Hospital Name	Time Period
Recent or Significant Ho		Hospital Name	Time Period
		Hospital Name	Time Period
		Hospital Name	Time Period
		Hospital Name	Time Period
		Hospital Name	Time Period
		Hospital Name	Time Period
		Hospital Name	Time Period
		Hospital Name	Time Period Date