Memorial Hermann Health Centers for Schools
History Form

Student Name: _____ Date of Birth: _____

Current Medications: _____

Medication Allergies: ☐ NO ☐ YES Which medication? _____ What happens? _____

Student's Medical History *(Check all problems since birth):*

Hospitalized: ☐ Never been hospitalized ☐ Hospitalized for: _____ When: _____

Past Surgery: ☐ Appendectomy ☐ Circumcision ☐ PE tubes in ears ☐ Tonsillectomy ☐ Umbilical or groin hernia repair
☐ Other surgery: _____ When: _____ ☐ Never had surgery

Head and Eyes: ☐ Dental caries ☐ Hearing loss ☐ Near sighted ☐ Recurrent ear infection ☐ Seasonal allergies ☐ Strabismus
☐ Wears glasses or contact lenses

Respiratory: ☐ Asthma ☐ Pneumonia ☐ RSV

Heart: ☐ Heart problem ☐ Heart murmur ☐ High blood pressure

GI: ☐ Constipation ☐ GERD (reflux)

Endocrine: ☐ Diabetes Type 1 or Type 2 ☐ Thyroid problem

Urinary: ☐ Bed wetting ☐ Kidney infection ☐ Undescended or absent testicle ☐ Recurrent bladder/urine infections

Skin: ☐ Acne ☐ Eczema ☐ Contact dermatitis

Nutrition: ☐ Food allergy ☐ Lactose intolerance ☐ Weight problem

Blood problem or Cancer: ☐ Iron deficiency anemia ☐ Sickle cell trait or disease Cancer Type: _____

Nervous or Muscle Systems: ☐ Febrile seizure ☐ Fracture ☐ Head trauma/concussion ☐ Migraines ☐ Scoliosis ☐ Seizures

Development: ☐ ADHD ☐ Anxiety ☐ Autism ☐ Behavior problem ☐ Depression ☐ Developmental delay
☐ Learning problem ☐ Speech problem

Any other problems: _____

Girls: Age at 1st period: _____ ☐ Regular ☐ Not Regular Time between periods usually: _____ # days on period _____

Bad cramps: ☐ No ☐ Yes Skipped or missed periods in past year: ☐ No ☐ Yes How long until period started again? _____

Family History *(which family member has the problem – mother, father, grandparent, aunt, uncle, brother or sister):*

☐ No health problems (unremarkable) ☐ do not know (unknown)

	Mother	Father	Grandparent	Aunt	Uncle	Brother	Sister
Diabetes: ☐ Type 1 ☐ Type 2							
High Blood Pressure							
Heart Disease							
Stroke							
Mental Health Disease or Problem Diagnosis:							
Cancer Type:							
Other problems:							

Social History: Lives with: _____ Immunizations: ☐ Up to date ☐ Needs: _____

Smokers at home: ☐ No ☐ Yes If YES: ☐ Inside ☐ Outside ☐ Both ☐ Pets: _____

By electronically signing this document, I acknowledge that, for all purposes herein, my electronic signature shall be deemed the same as my original signature. As the parent/legal guardian and having authority to sign the above document, I acknowledge that I have read the document, the information provided is accurate to the best of my knowledge, and any questions I have, have been answered to my satisfaction.

☐ AM
☐ PM

Parent / Guardian Signature	Print Name	Relationship to patient	Date	Time

MEMORIAL HERMANN

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16415 (6/21)