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)

<table>
<thead>
<tr>
<th>Diabetes: ☐ Type 1 ☐ Type 2</th>
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</thead>
<tbody>
<tr>
<td>High Blood Pressure</td>
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<tr>
<td>Heart Disease</td>
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<tr>
<td>Stroke</td>
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<tr>
<td>Mental Health Disease or Problem</td>
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<tr>
<td>Diagnosis: ________</td>
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<tr>
<td>Cancer</td>
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<tr>
<td>Type: ________</td>
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<td>Other problems: ________</td>
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</tbody>
</table>

Mother Father Grandparent Aunt Uncle Brother Sister

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

History Form for the Health Centers for Schools

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