HEALTH HISTORY
Confidential

Name:_____ _____   Date:_____

Age: _____Date of last physical exam: _____

REOCCURRING SYMPTOMS:

- ☐ chills
- ☐ depression
- ☐ dizziness
- ☐ fainting
- ☐ fever
- ☐ forgetfulness
- ☐ headache
- ☐ loss of sleep
- ☐ loss of weight
- ☐ nervousness
- ☐ numbness
- ☐ sweats
- ☐ poor appetite
- ☐ bloating
- ☐ bowel changes
- ☐ constipation
- ☐ diarrhea
- ☐ excessive hunger
- ☐ excessive thirst
- ☐ excessive gas
- ☐ hemorrhoids
- ☐ indigestion
- ☐ nausea
- ☐ rectal bleeding
- ☐ stomach pain
- ☐ vomiting
- ☐ vomiting blood
- ☐ bleeding gums
- ☐ blurred vision
- ☐ crossed eyes
- ☐ difficulty swallowing
- ☐ double vision
- ☐ earaches
- ☐ ear discharge
- ☐ hay fever
- ☐ lose of hearing
- ☐ frequent nose bleeds
- ☐ persistent cough
- ☐ ringing in ears
- ☐ sinus problems
- ☐ vision restraints   glasses/contacts

pain, weakness, numbness in:

- ☐ arms
- ☐ legs
- ☐ back
- ☐ feet
- ☐ hips
- ☐ neck
- ☐ shoulders

- ☐ blood in urine
- ☐ frequent urination
- ☐ painful urination
- ☐ lack of bladder control

- ☐ chest pain
- ☐ high/low blood pressure
- ☐ swelling of ankles
- ☐ irregular/rapid heartbeat
- ☐ bruise easily
- ☐ hives
- ☐ excessive itching
- ☐ rash
- ☐ scars
- ☐ sore that won't heal
- ☐ pregnant? # children _____

MEDICATIONS:

_____

_____

_____

ALLERGIES:

_____

_____

_____

CONDITIONS:

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Gonorhea
- ☐ Gout
- ☐ Heart Desease
- ☐ Hepatitus
- ☐ Hernai
- ☐ Herpes
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Migraine Headaches
- ☐ Mono-within last 6 months
- ☐ Multiple Sclerosis
- ☐ Pacemaker
- ☐ Pneumonia within last 6 months
- ☐ Polio
- ☐ Prostate problem
- ☐ Psychiatric care
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid problem
- ☐ Ulcers
- ☐ Vaginal Infection
- ☐ Venereal disease

HEALTH HISTORY

Confidential
~continued~

Serious illness or injuries?

_____

_____

Have you ever been hospitalized? If so why and what age?

_____

_____

_____

_____

Health habits:
- ☐ caffeine
- ☐ tobacco
- ☐ street drugs
- ☐ alcohol
- ☐ other:_____

To the best of my knowledge, the above information is complete and correct. I understand that it is my reponsibility to inform STAR if my minor child has a change in health.

_____   _____
Signature of parent/gardian   date   relationship to student

_____
printed name of parent/gardian

_____
reviewed by   date