

YORKTOWN CENTRAL SCHOOL DISTRICT
Yorktown Heights, New York

PRE-PHYSICAL HEALTH HISTORY FORM

Date _____

(Please complete this form prior to your child's physical with our school physician)

Student's Name _____ Date/Place of Birth _____

School _____ Male Female

MEDICAL HISTORY

DATES

Chicken Pox _____
 Measles (Rubeola) _____
 Mumps _____
 Hepatitis _____
 Rubella _____
 Colds/Sore Throats _____
 Scarlet Fever _____
 Rheumatic Fever _____
 Pneumonia _____
 Tuberculosis (or contact) _____
 Asthma _____
 Anemia _____
 Chronic Abdominal Pain _____
 Colitis _____
 Peptic Ulcer Disease _____

MEDICAL HISTORY

DATES

Convulsive Disorder _____
 Fainting Spells _____
 Diabetes _____
 Thyroid Disease _____
 Ear Conditions _____
 Heart Disease/Murmur _____
 Hypertension _____
 Kidney Disease/Cystitis _____
 Hernia _____
 Arthritis _____
 Lyme Disease _____
 Mononucleosis _____
 Physical Handicap _____
 Vision Difficulty _____
 Glasses/Contacts _____
 Allergies _____

OTHER SIGNIFICANT HEALTH HISTORY

(Please answer the following questions – Yes or No)

Has your child experienced:	<u>Yes</u> or <u>No</u>	<u>Date</u>
1. A loss of consciousness during the last year? Describe incident _____	_____	_____
2. Head Injury	_____	_____
3. Accidents or injuries? Example: Bone injury	_____	_____
4. Hospitalizations? <u>Reason:</u>		
Outpatient _____	_____	_____
Illness _____	_____	_____
Surgery _____	_____	_____
5. Recent illness (other than a cold)?	_____	_____
6. Significant Family History _____		

Does your child take daily medication? _____ Kind/Reason _____
 Most recent dental examination? _____

 SIGNATURE OF PARENT/GUARDIAN