



THE WOODHALL SCHOOL
ACADEMIC YEAR 2016 – 2017
STUDENT/ FAMILY HEALTH & MEDICAL HISTORY

HEALTH

STUDENT NAME _____ BIRTHDATE ____ / ____ / ____

Do you have or have you ever had ... ?	Y	N
Alcohol or other drug use		
Anemia/ blood disorder		
Asthma/ wheezing		
Back problems		
Cancer/ tumor		
Chest pain/ shortness of breath		
Dental problems		
Depression		
Diabetes		
Ear, nose, throat problems		
Eye problems		
Fainting/ loss of consciousness		
Fractures/ sprains/ dislocations		
Headaches/ migraines		
Head injury/ concussion		
Heart disease		
High blood pressure		
Intestinal/ digestive problems		
Kidney disease/ bladder infections		
Mononucleosis		
Pneumonia		
Recent weight change/ eating concerns		
Seizures		
Significant anxiety/ depression		
Sinusitis		
Skin problems		
Special diet		
Thyroid/ hormone problems		
Tobacco use		
Other illness		

PERSONAL HISTORY									
ALLERGIES	To medication: _____ _____								
	To food: _____ _____								
	Other: _____ _____								
HOSPITALIZATIONS SURGERIES	<table border="1"> <thead> <tr> <th>Date</th> <th>Description</th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table>	Date	Description						
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MAJOR ILLNESS	<table border="1"> <thead> <tr> <th>Date</th> <th>Description</th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table>	Date	Description						
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DENTAL/ VISION INFORMATION	
Eye/Vision Issues?	<input type="checkbox"/> Glasses <input type="checkbox"/> Contact Lens <input type="checkbox"/> No issues Last eye examination _____
Dental Issues?	<input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other: _____

FAMILY HISTORY (BIOLOGICAL)			
Relationship	Age	State of Health	Medical Issues
Father			
Mother			
Siblings			

If you answered YES to any of the above, please explain: _____

Unless all medical information is supplied, The Woodhall School is at a disadvantage in caring and seeking proper medical attention for the student named above.

I am aware of this and have completed the medical forms accurately and completely to the best of my knowledge.

Signature of Parent/Guardian

Date