EAST ISLIP SCHOOL DISTRICT
HEALTH HISTORY QUESTIONNAIRE

RECENT MEDICAL-SURGICAL HISTORY

Has student ever had any of the following:	No	Yes
1. Any injuries requiring medical attention	☐	☐
2. Any illness lasting more than five (5) days	☐	☐
3. Taking any medicine or under a physician's care at this time	☐	☐
4. Any feeling of dizziness, faintness, or fatigue after heavy exertion	☐	☐
5. Wears glasses or contact lenses	☐	☐
6. A surgical operation or fracture	☐	☐
7. Treated in a hospital or Emergency Room	☐	☐
8. Any reason why this person cannot participate in any activity	☐	☐
9. Any known allergies	☐	☐
10. Any chronic diseases	☐	☐
11. Head injury	☐	☐
12. Concussion	☐	☐
13. Eye Disorder	☐	☐
14. Ear Disorder	☐	☐
15. Nose Disorder	☐	☐
16. Throat Disorder	☐	☐
17. Dental Disorder	☐	☐
18. Heart: Murmur	☐	☐
Rheumatic Fever	☐	☐
19. Lungs: Pneumonia	☐	☐
Bronchitis	☐	☐
Asthma	☐	☐
20. Kidney, Bladder Disorder	☐	☐
21. Abdominal, Intestinal Disorder	☐	☐
22. Hernia	☐	☐
23. Undescended Testicles	☐	☐
24. Bones, Joints: Fractures	☐	☐
Dislocations	☐	☐
Others	☐	☐
25. Muscle, Nerve Disorder	☐	☐
26. Seizure Disorder	☐	☐
27. Diabetes	☐	☐
28. Hospital Admissions	☐	☐

If you answered yes to any of the above, please explain on back.

Student's Name: _____
(Please Print)
Parent/Guardian Signature: _____ Date: _____