



Medical History Questionnaire

Student Wellness Center - St. Francis

Name _____ DOB _____ Sex M F

Pharmacy _____ Primary Care Provider _____

Medications _____ Allergies _____

Students Medical History

Has your student ever had:

Asthma/Wheezing ☐ Yes ☐ No

Asthma Action Plan ☐ Yes ☐ No

Pneumonia ☐ Yes ☐ No

Chicken Pox (Year _____) ☐ Yes ☐ No

Frequent Ear Infections ☐ Yes ☐ No

Vision Problems ☐ Yes ☐ No

Hearing Problems ☐ Yes ☐ No

Skin Problems/Eczema/Hives ☐ Yes ☐ No

TB/Lung/Disease ☐ Yes ☐ No

Liver Disease/Hepatitis ☐ Yes ☐ No

Diabetes ☐ Yes ☐ No

Kidney Disease ☐ Yes ☐ No

Bladder Infections ☐ Yes ☐ No

Menstrual Problems ☐ Yes ☐ No

Physical or Learning Disabilities ☐ Yes ☐ No

Bleeding Disorders/Hemophilia ☐ Yes ☐ No

Sexual Transmitted Infections ☐ Yes ☐ No

Emotional/Behavioral Problems ☐ Yes ☐ No

Depression/Suicidal Thoughts ☐ Yes ☐ No

Hospitalizations/Surgeries ☐ Yes ☐ No

Physical/Sexual Abuse ☐ Yes ☐ No

Emotional Abuse ☐ Yes ☐ No

Bone or Joint Injuries ☐ Yes ☐ No

Mobility/Coordination Problems ☐ Yes ☐ No

Dental Problems ☐ Yes ☐ No

Obesity/Overweight ☐ Yes ☐ No

Eating Disorders ☐ Yes ☐ No

Anorexia Nervous ☐ Yes ☐ No

Bulimia ☐ Yes ☐ No

Intellectual Developmental Disorder ☐ Yes ☐ No

Attention Deficit Disorder ☐ Yes ☐ No

Dental Exam ☐ Yes ☐ No

Seat Belt Use ☐ Yes ☐ No

Other Concerns:

*Hospital/Surgery, List and Year:

Reviewed by:

Family Medical History

Has any parent(P), grandparent(GP), aunt(A), uncle(U), sister(S), or brother(B) had:

Allergies(List) (Food or Medicine) ☐ Yes ☐ No

Asthma/Wheezing ☐ Yes ☐ No

TB/Lung Disease ☐ Yes ☐ No

Cystic Fibrosis ☐ Yes ☐ No

HIV/AIDS ☐ Yes ☐ No

Heart Disease ☐ Yes ☐ No

Sudden Cardiac Death ☐ Yes ☐ No

High Blood Pressure/Stroke ☐ Yes ☐ No

High Cholesterol ☐ Yes ☐ No

Blood Disorders ☐ Yes ☐ No

Sickle Cell ☐ Yes ☐ No

Anemia ☐ Yes ☐ No

Thalassemia ☐ Yes ☐ No

Clotting Disorders ☐ Yes ☐ No

Diabetes ☐ Yes ☐ No

Seizures ☐ Yes ☐ No

Mental Illness ☐ Yes ☐ No

Depression ☐ Yes ☐ No

Suicide Attempts ☐ Yes ☐ No

Cancer ☐ Yes ☐ No

Breast ☐ Yes ☐ No

Cervical ☐ Yes ☐ No

Colorectal ☐ Yes ☐ No

Other _____ ☐ Yes ☐ No

Birth Defects ☐ Yes ☐ No

Hearing Loss ☐ Yes ☐ No

Speech Problems ☐ Yes ☐ No

Kidney Disease ☐ Yes ☐ No

Alcohol/Drug Abuse ☐ Yes ☐ No

Hepatitis/Liver Disease ☐ Yes ☐ No

Thyroid Disease ☐ Yes ☐ No

Learning Problems ☐ Yes ☐ No

Attention Deficit Disorder ☐ Yes ☐ No

Intellectual Developmental Disorder ☐ Yes ☐ No

Family Violence ☐ Yes ☐ No

Other Concerns:

Has any family member ever had an unexplained, unexpected death before age 50? ☐ Yes ☐ No

Date of Review: