

EAST ISLIP SCHOOL DISTRICT
HEALTH HISTORY QUESTIONNAIRE

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

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

Student's Name: _____

(Please Print)

Parent/Guardian Signature: _____ Date: _____