HEALTH SERVICES
CITY SCHOOL DISTRICT OF NEW ROCHELLE

Adrienne Weiss-Harrison, M.D. Medical Director
Barbara Ehrenreich, C.P.N.P Nurse Practitioner

Pediatric and Adolescent School Health History

Date form completed: _____ School: _____ Grade: _____
❒ In Person Interview ❒ Telephone Interview _____
(state reason: _____)

General Information:
Child's Name: _____ Sex: ❒M ❒F DOB: ___/___/___ Age:_____

Address: _____
STREET CITY STATE ZIP CODE

Home Phone: _____Cell Phone: _____ Office Phone: _____ Parent email: _____
Mother's Name: _____ Age: _____
Father's Name: _____ Age: _____
Brothers and Sisters Names:
1. _____ Sex: ❒M ❒F Date of Birth: ___/___/___
2. _____ Sex: ❒M ❒F Date of Birth: ___/___/___
3. _____ Sex: ❒M ❒F Date of Birth: ___/___/___
4. _____ Sex: ❒M ❒F Date of Birth: ___/___/___

Are parents: ❒Married ❒Divorced ❒Separated ❒Remarried ❒Single
Who cares for the child after school: _____

Birth History:
Birth weight: ___ lbs. ___ oz. Weeks gestation: ____ Hospital born at: _____

Pregnancy: ❒ Normal ❒ Complications: _____

Type of delivery: ❒ NSVD ❒C-Section ❒Breech ❒Forceps ❒Other
Reason: _____
Problems during pregnancy: _____
Problems during delivery: _____
Problems after delivery: _____
(If NICU, describe course on separate paper)

Developmental History:
At what age did this child?
Roll over _____ months
Sit up without support _____ months
Crawl _____ months
Walk alone _____
Talk (two words together) _____
Bladder trained _____
Bowel trained _____

Did your child experience feeding difficulties during infancy?
If yes, please describe: _____

Did your child have any sleep problems during infancy?
If yes, please describe: _____

What was your child's temperament during infancy: _____

_____

What was your child's temperament as a toddler: _____

_____

Past Medical History:
Allergies to food or medicines? ❒Yes ❒ No Name of allergens: _____

If yes, please describe: _____

_____
(If yes, complete allergy history for registration)
Immunizations up to date? If not, please elaborate: _____

_____

Medications (including name, dosage and frequency) taken:
1. _____
2. _____
3. _____

Hospitalizations, accidents or broken bones (note any ICU admissions)

Date	Child's Age	Name of hospital	Reason for hospitalization
____	_____	_____	_____
____	_____	_____	_____
____	_____	_____	_____

Major or serious illnesses

Date	Child's Age	Illness	Physician	Treatment
____	_____	_____	_____	_____
____	_____	_____	_____	_____
____	_____	_____	_____	_____

Surgical procedures:

Date	Child's Age	Physician	Procedure
____	_____	_____	_____
____	_____	_____	_____
____	_____	_____	_____

Review of Systems:

Indicate which of the following conditions or problems the child has had. Give details and dates for the problems checked:

[ ]Skin trouble
[ ]Eye or vision problems]
[ ]Eyeglasses
[ ]Frequent ear infections
[ ]Difficulty hearing
[ ]Frequent nose bleeds
[ ]Nasal allergies]
[ ]Sinus problems
[ ]Frequent sore throats
[ ]Thyroid problems
[ ]Pneumonia
[ ]Asthma
[ ]Any other lung problems
[ ]Heart murmur
[ ]Any other heart problems
[ ]Jaundice
[ ]Frequent stomach aches
[ ]Frequent diarrhea
[ ]Frequent constipation
[ ]Black or tarry stools
[ ]Kidney or bladder infection
[ ]Frequent or painful urination
[ ]Bedwetting
[ ]Joint aches or pains
[ ]Orthopedic or bony problems
[ ]Seizures
[ ]Frequent headaches
[ ]Skin rashes
[ ]Insect bite reactions
[ ]Anemia
[ ]Speech problems
[ ]Increased lead levels
[ ]Current health concerns/issues

Girls: Menstrual History
Onset: _____
Frequency: _____
Cramps: ❒ Yes ❒ No
Irritability: ❒ Yes ❒ No
Other: _____

[Note any important details in the space below.]

Pediatrician/FP/NP: _____ Phone _____ Address_____

Specialist 1: _____ Phone _____ Address _____
[specify specialty]

Specialist 2: _____ Phone _____ Address _____
[specify specialty]

Family History:

Father's country of birth: _____ Mother' country of birth: _____
Father's occupation: _____ Mother's occupation: _____
Father's Education: _____ Mother's Education: _____

Does the child have any blood relatives (father, mother ,brother, sister, father's side or mother's side who have the following conditions? (mark with a check)

[ ]Birth deformity _____
[ ]Mental retardation _____
[ ]Convulsions, epilepsy _____
[ ]Mental illness _____
[ ]Family or inherited disease _____
[ ]Death in childhood _____
[ ]Eye problems _____
[ ]Hearing Problems _____
[ ]Asthma _____
[ ]Hay fever _____
[ ]Allergies _____
[ ]Severe Anemia _____
[ ]Sickle Cell disease _____
[ ]Bleeding tendencies _____
[ ]Tuberculosis _____
[ ]Diabetes _____
[ ]Heart Attack (under age 50) _____
[ ]Cancer _____
[ ]High blood pressure _____
[ ]Kidney problems _____
[ ]Obesity _____
[ ]Thyroid Problems _____
[ ]ADD/ADHD _____
[ ]Speech issues _____
[ ]Developmental delay _____
[ ]Learning disability _____
[ ]Autism _____

For all conditions checked please describe: _____

_____

_____

Social History:

Living situation: ❒ Homeowner ❒ Home rental
❒ Apartment owner ❒ Apartment rental

Who lives in the home? _____

Does child have: Own room ❒ Yes ❒ No Own bed ❒ Yes ❒ No

Pets in the home? ❒ Yes ❒ No If yes, specify: _____

Does anyone smoke in the home? ❒ Yes ❒ No

First language of child: _____ Language spoken at home: _____

_____
Signature of School Nurse Date