UNM SCHOOL of MEDICINE

SCHOOL BASED HEALTH CENTER (Elementary School)
STUDENT HEALTH QUESTIONNAIRE

School year _____

Child's Name: _____ _____ _____
Last **First** **Middle Initial**

Date of Birth: _____ Age: _____ Grade: _____ Student ID #: _____
Month/Date/Year

Today's Date: _____ School Name: _____
Month/Date/Year

The information you provide is **STRICTLY CONFIDENTIAL,** (except if your child is being abused, about to harm someone else or is suicidal). Its purpose is to help us give your child better care. We ask that you fill out the form completely, but you may skip any question you do not wish to answer.

Family Information	
Your Name	How are you related to the above named child?

1. With whom does your child live? (Check All That Apply)

_____ both natural parents _____ stepmother _____ alone

_____ mother _____ stepfather _____ brother(s)/ages: _____

_____ father _____ guardian _____ sister(s)/ages: _____

_____ adoptive parents _____ other (explain) _____

2. Does anyone else take care of your child? □ Yes □ No

If yes, who? _____

3. Does your child have any health problems? □ Yes □ No

If yes, what? _____

4. Where do you take your child when he/she is sick? _____

5. Where do you take your child for dental care? _____

6. Does your child have any allergies to any medications? □ Yes □ No

If yes, what? _____Type of reaction_____

7. Is your child taking any medications (over the counter, prescription, homeopathic or herbs)? □ Yes □ No

If yes, what? _____

8. Has your child ever been hospitalized or had surgery? □ Yes □ No

If yes, when? _____ Where? _____ Why? _____

9. Do you have any concerns about your child? □ Yes □ No

If yes, what? _____

10. Are the child's parents: (Please Circle Answer) Married Separated Divorced Non-Married Parents

If divorced, when? _____

11. Do the child's parents work outside the home? □ Yes □ No

If yes, what type of work do they do? Mother _____ Father _____

Family Medical History

12. Does the child's mother, father, siblings or grandparents have any of the following?

		If yes, who?			**If yes,** who?
High Blood Pressure	□ Yes □ No		Learning Problems	□ Yes □ No	
Diabetes	□ Yes □ No		Mental Illness	□ Yes □ No	
Lung Problems	□ Yes □ No		Nerve Problems	□ Yes □ No	
Asthma	□ Yes □ No		Drinking Problems	□ Yes □ No	
Heart Problems	□ Yes □ No		Drug Problems	□ Yes □ No	
Cancer	□ Yes □ No		Other _____	□ Yes □ No	
Miscarriages	□ Yes □ No				

Family Health Habits

13. How often does your child use a seatbelt (car seat)? (Please Circle Answer)

A. Never B. Rarely C. Sometimes D. Often E. Always

14. Does your child ride a bicycle, skateboard or roller blade? □ Yes □ No

If yes, how often does he/she use a helmet? (Please Circle Answer)

A. Never B. Rarely C. Sometimes D. Often E. Always

15. Does your child need information about safety (strangers or unknown adults, matches, etc.)? □ Yes □ No

16. How many hours of sleep does your child get each night? _____ hours.

17. Do you feel that you live in a unsafe place? □ Yes □ No

18. Have there been any major changes in your family such as: (Check All That Apply)

___ moving ___ death of family member ___ violence or serious accident

___ physical, emotional, sexual abuse ___loss of job ___ birth ___ other

19. Do you have a gun at home? □ Yes □ No

If yes, is it locked? □ Yes □ No

20. Does anyone in your household smoke? □ Yes □ No

21. Do you currently smoke cigarettes? □ Yes □ No

If yes, how many cigarettes do you smoke per day? _____ cigarettes a day

School History

22. Did/does your child attend preschool? □ Yes □ No

23. Do you have any concerns about your child's school performance? □ Yes □ No

If yes, what? _____

24. Do you have any concerns about your child's relationships with teachers? □ Yes □ No

25. Do you have any concerns about your child's relationships with other students? □ Yes □ No

26. Do you have any concerns about your child's relationships with siblings or other family members? □ Yes □ No

27. If over 4 years old, does your child have a best friend? □ Yes □ No

28. Does your child participate in sports/exercise or have hobbies, special interests or talents? □ Yes □ No

If yes, what _____ How often? _____ How long? _____

Medical History

Check if your child has any problems with the following:

Constitution/endocrine
___ Overly tired or sleepy
___ Fevers/chills/excessive sweating
___ Unexplained weight loss/gain

Eyes
___ Squinting/"crossed eyes"/wandering eye
___ Redness, discharge
___ Vision problem

Ears/Nose/Throat
___ Unusually loud voice
___ Hard of hearing
___ Mouth breathing/snoring
___ Bad breath

___ Frequently runny nose
___ Problems with teeth/gums
___ Sore throat

Respiratory
___ Cough/wheeze
___ Short of breath

Gastrointestinal
___ Nausea/vomiting/diarrhea
___ Constipation
___ Blood in bowel movement

Cardiovascular
___ Tires easily with exertion
___ Shortness of breath
___ Fainting

Blood/Lymph
___ Unexplained lumps
___ Easy bruising/bleeding

Genitourinary
___ Bedwetting
___ Frequent urination
___ Pain with urination
___ Discharge: penis or vagina

Neurological
___ Headache
___ Weakness
___ Clumsiness
___ History of head injury/passed out/concussion

Musculo/Skeletal
___ Muscle/joint pain
___ Crooked Spine
___ Limp

Allergy
___ Hay fever/itchy eyes
___ Other allergies

Skin
___ Rashes
___ Unusual moles

Developmental/Emotional
___ Speech problems
___ Anxiety/stress
___ Problems with sleep/nightmares
___ Depression
___ Nail biting/thumb sucking
___ Bad temper/breath holding/jealousy
___ Difficulty paying attention
___ Difficulty following rules

Nutritional/Eating habits
___ Allergies ___ Lead poisoning
___ Cravings
___ Over-eating
___ Under-eating

What is the best way to reach you, if we need to? Home Phone #_____ Cell Phone # _____

Mailing Address _____

THANK YOU!

Reviewed By: _____ Date: _____

Referred To: _____