



The Catholic High School Student Health Questionnaire

Name: _____ Age _____ DOB _____ YOG _____

General Medical History- to be completed by Parent or Legal Guardian

1. Does your child have any current ongoing medical condition? If yes, please explain

2. Please list any medications your daughter takes. _____
3. Is your child on medication for ADHD, ADD, or an antidepressant? If so, please list the medication _____
4. Are there any emergency medications your daughter uses (epi-pen, inhaler, etc)?

5. Has your child ever been diagnosed with a HEAD INJURY/CONCUSSION by a medical professional? If YES, How many times
_____ Date of most recent Concussion _____
6. Age Menstruation began _____
7. To the best of your knowledge has your child had any problems with the following:

	Yes	No	Comment		Yes	No	Comment
Allergies: Medicine				Head Injury			
Allergies: Food/Seasonal				Heart Problems			
Anaphylaxis-severe allergic reactions				Hospitalization			
Anemia				Learning Disabilities			
Asthma				Meningitis			
Behavior/Emotional				Migraines			
Birth Defects				Nasal Problems			
Bleeding Problems				Physical Disabilities			
Dental				Prematurity			
Diabetes				Seizures			
Ear problems/Deafness				Sickle Cell Disease			
Eye or Vision Problems				Speech Problems			
GI problems				Surgery			
GU problems				Other			

Please answer the following to the best of your knowledge.

	Yes	No
8. Has your child ever had one of the following? (please circle) Mononucleosis Hepatitis Tuberculosis Other infectious Disease _____		
9. Does your child have any rashes, pressure sores, or other skin problems?		
Family History		
10. Has anyone in your immediate family had or have: (circle all that apply) Asthma Diabetes Migraines Kidney Problems Epilepsy High Blood Pressure If yes, note relationship to student _____		
Cardiovascular/Respiratory		
11. Has your doctor ever told you that your child has: (circle all that apply) High Blood Pressure Heart Murmur Heart Infection Enlarged Heart		
12. Has your child ever passed out or nearly passed out DURING or AFTER exercise?		
13. Has your child ever had chest discomfort, pain, or pressure during exercise?		
14. Does your child cough, wheeze, have shortness of breath or use an inhaler/asthma medication?		
15. Has your child ever had problems exercising in heat or have a heat related illness?		
Orthopedic		
16. Has your child ever had a muscle strain or sprain, pull, tear, fracture, or dislocation? If YES, specify body part _____		
Head and Neck		
17. Has your child ever had a neck injury?		

18. Any Other relevant Medical History:

Parent Name: _____ Parent Signature: _____ Date: _____