



Patient's Name: _____

Date of Birth: _____

School: _____

CONFIDENTIAL ASSESSMENT OF FAMILY HEALTH HISTORY

To the best of your knowledge, does anyone in your family have a history of any of the following conditions?
If yes, state which family member has the medical problem.

	Yes	No	<i>Comments</i> (Indicate Which Family Member)
Asthma			
Cancer			
Heart Disease (heart attack before age 50)			
Elevated Cholesterol			
Depression, other Mental Illness			
High Blood Pressure			
Kidney Disease			
Diabetes			
Substance Abuse/Alcoholism			
Tuberculosis			
Other (describe)			

Does this student have any **allergies** to medication? If so please list _____

Parent/Guardian Signature _____

Date _____