

**PERKINS SCHOOL FOR THE BLIND  
HEALTH SERVICES  
STUDENT HEALTH HISTORY**

**STUDENT HEALTH HISTORY FORM (Admission History)**

*(To be completed by parent or guardian and signed by primary care provider at time of physical examination.)*

Name \_\_\_\_\_ D.O.B. \_\_\_\_\_

**Allergies** *Please list allergen and reaction to each.*

1. Drugs: \_\_\_\_\_
  2. Food: \_\_\_\_\_
  3. Environmental: \_\_\_\_\_
- Has this student been prescribed an Epi-Pen? Yes No If yes, for what allergen? \_\_\_\_\_

**Etiology (cause) of Disabilities** *Please describe:*

\_\_\_\_\_

**Birth History**

Birth Weight \_\_\_\_\_ Pregnancy term \_\_\_\_\_ Type of delivery \_\_\_\_\_  
Problems or issues in neonatal period? \_\_\_\_\_

**Developmental History** *Please specify at what age the following occurred or not at all:*

|                                   |  |
|-----------------------------------|--|
| Sitting alone _____               | Holding cup/toy/bottle independently _____ |
| Walking alone _____               | Feeding self _____                         |
| Toilet trained _____              | First words _____                          |
| Simple sentences or phrases _____ |  |

**Past Health Problems**

Hospitalizations \_\_\_\_\_

Surgeries \_\_\_\_\_

Chronic or recurrent problems \_\_\_\_\_

**Review of Systems** *Please circle response. If yes, please explain.*

Has student ever had:

- |  |     |    |                |
|--|-----|----|----------------|
| 1. Seizures?   | Yes | No | Explain: _____ |
| 2. Dizziness, fainting or passed out?                          | Yes | No | Explain: _____ |
| 3. Heat exhaustion/ sun stroke?                                | Yes | No | Explain: _____ |
| 4. Concussion/ knocked out?                                    | Yes | No | Explain: _____ |
| 5. Frequent headaches?   | Yes | No | Explain: _____ |
| 6. Knee, ankle or neck injuries?                               | Yes | No | Explain: _____ |
| 7. Broken bone or dislocation?                                 | Yes | No | Explain: _____ |
| 8. Cervical spine malformation?                                | Yes | No | Explain: _____ |
| 9. Any problems with heart/blood pressure?                     | Yes | No | Explain: _____ |
| 10. Coughing, wheezing or shortness of breath when exercising? | Yes | No | Explain: _____ |
| 11. Recurrent Skin Conditions?                                 | Yes | No | Explain: _____ |
| 12. Reaction to anesthesia?                                    | Yes | No | Explain: _____ |

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**Significant Family History** *Please circle response. If yes, please indicate relation to student.*

Does anyone in your family have:

- |   |     |    |                 |
|---|-----|----|-----------------|
| 1. Epilepsy or seizures?                    | Yes | No | Relation: _____ |
| 2. Hypertension or stroke?                  | Yes | No | Relation: _____ |
| 3. Cardiac disease or death before age 50?  | Yes | No | Relation: _____ |
| 4. Autoimmune disorders, allergies, asthma? | Yes | No | Relation: _____ |
| 5. Diabetes?                                | Yes | No | Relation: _____ |
| 6. Genetic disorders?                       | Yes | No | Relation: _____ |
| 7. Learning disorders?                      | Yes | No | Relation: _____ |
| 8. Psychiatric illness?                     | Yes | No | Relation: _____ |
| 9. Reaction to anesthesia?                  | Yes | No | Relation: _____ |
| 10. High cholesterol?                       | Yes | No | Relation: _____ |

**Household members**

*Please list name and age of all persons student lives with in home.*

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Are there any pets at home?      Yes    No      If yes, what? \_\_\_\_\_

Does anyone smoke in the home?    Yes    No

**Self Care Skills** *Please circle appropriate skill level.*

|                     |             |                  |                   |
|---------------------|-------------|------------------|-------------------|
| Toileting           | Independent | Needs assistance | Unable to perform |
| Brushing teeth      | Independent | Needs assistance | Unable to perform |
| Bathing             | Independent | Needs assistance | Unable to perform |
| Feeding             | Independent | Needs assistance | Unable to perform |
| Shaving             | Independent | Needs assistance | Unable to perform |
| Care during menses  | Independent | Needs assistance | Unable to perform |
| Dressing            | Independent | Needs assistance | Unable to perform |
| Undressing          | Independent | Needs assistance | Unable to perform |
| Wheelchair mobility | Independent | Needs assistance | Unable to perform |
| Transfers           | Independent | Needs assistance | Unable to perform |
| Walking/ambulation  | Independent | Needs assistance | Unable to perform |
| Recognizing danger  | Independent | Needs assistance | Unable to perform |

**Communication Skills**

Speech in single words? \_\_\_\_\_ Short Phrases? \_\_\_\_\_ Short Sentences? \_\_\_\_\_

If no speech, state form of communication used:

- Vocalizations
- Gestures
- Sign Language
- Communication board/book
- Other \_\_\_\_\_

**Social Behavior** *Please rate each item.*

|                                     |              |                   |      |
|-------------------------------------|--------------|-------------------|------|
| Temper control/Self-control         | Good         | Fair              | Poor |
| Compliance/cooperation              | Good         | Fair              | Poor |
| Respect for property                | Good         | Fair              | Poor |
| Relationship/interaction with peers | Good         | Fair              | Poor |
| Relationship/interaction with staff | Good         | Fair              | Poor |
| Attention span                      | Good         | Limited           | Poor |
| Other                               | Impulsive    | Hyperactive       |      |
| Aggression                          | Self abusive | Abusive to others |      |

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**Social Behavior, continued**

*Please describe any behavioral problems or situations, frequency, and possible precipitating factors that require special attention:*

*Please describe methods used to control problem behaviors and effectiveness of these techniques:*

**Current Diet/Feeding program**

*Please describe any special diet, food consistency, adaptive tableware, etc.*

Some food likes: \_\_\_\_\_  
Food dislikes: \_\_\_\_\_

Does student have any episodes of coughing, gagging or choking when eating? *Please describe.*

Does student have any episodes of coughing, gagging or choking when drinking? *Please describe.*

Has student ever had a swallow study? \_\_\_\_\_ *If yes, please attach report.*

**Elimination Patterns**

How many times per day does student usually urinate? \_\_\_\_\_

Has student had urinary tract infections? If so, when? \_\_\_\_\_

How often does student have bowel movement? \_\_\_\_\_

Has constipation been a problem? \_\_\_\_\_

If so what effective treatment, if any, has been used? \_\_\_\_\_

For Girls: Has menstruation started? If so, at what age? \_\_\_\_\_

How many days does menstrual period usually last? \_\_\_\_\_

Are periods regular? How many days between periods? \_\_\_\_\_

Does student have discomfort before or during menses? \_\_\_\_\_ If so, how is this indicated? \_\_\_\_\_

**Sleep patterns**

Usual bedtime? \_\_\_\_\_ Usual wake time? \_\_\_\_\_

Does student have trouble getting to sleep? \_\_\_\_\_

Trouble with staying asleep? \_\_\_\_\_

Nightmares? \_\_\_\_\_

Need for toileting during night? \_\_\_\_\_

Bedwetting? \_\_\_\_\_

Other issues? \_\_\_\_\_

**Other Comments**

Physician or Nurse Practitioner Name (**PLEASE PRINT CLEARLY**) \_\_\_\_\_ Date \_\_\_\_\_

Physician or Nurse Practitioner Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_