

Cornwell Center- Health History

Name of Participant: _____ DOB _____ Age _____

Allergies: Please list ALL known medication, food and other allergies

Medications: Please list ALL medications being taken and ANY dietary restrictions

General Questions (Explain "yes" answers below)

- | | | |
|---|---|---|
| 1. Had any recent injury, illness or infections disease? | Y | N |
| 2. Have a chronic or recurring illness/condition? | Y | N |
| 3. Ever been hospitalized? | Y | N |
| 4. Ever had surgery? | Y | N |
| 5. Have frequent headaches? | Y | N |
| 6. Ever had a head injury? | Y | N |
| 7. Ever been knocked unconscious? | Y | N |
| 8. Wear glasses, contact or protective eye wear? | Y | N |
| 9. Ever had frequent ear infections? | Y | N |
| 10. Ever passed out during or after exercise? | Y | N |
| 11. Ever been dizzy during or after exercise? | Y | N |
| 12. Ever had seizures? | Y | N |
| 13. Have an orthodontic appliance being brought to after school? | Y | N |
| 14. Ever had emotional difficulties for which professional help was sought? | Y | N |
| 15. Ever had back problems? | Y | N |
| 16. Ever had problems with joints (e.g knees, ankles)? | Y | N |
| 17. Ever had chest pain during or after exercise? | Y | N |
| 18. Had any skin problems (e.g. itching, rash, acne)? | Y | N |
| 19. Have diabetes? | Y | N |
| 20. Have asthma? | Y | N |
| 21. Have mononucleosis in the past 12 months? | Y | N |
| 22. Had problems with diarrhea/constipation ? | Y | N |
| 23. Have problems with sleepwalking? | Y | N |
| 24. If female, have an abnormal menstrual history? | Y | N |
| 25. Have a history of bed wetting? | Y | N |
| 26. Ever had an eating disorder? | Y | N |
| 27. Ever had high blood pressure? | Y | N |
| 28. Ever been diagnosed with a heart murmur? | Y | N |

Please explain any "yes" answers, noting the number of the question.
