METRO CARE CONNECTION
Cedar Rapids Community School District
School-Based Health Centers & Services

Medical History

Date_____

Child's Name_____ Date of Birth_____

Student Medical History
Has your child had any of the following conditions?

- ❑ Allergies to food or medication
- ❑ Anemia (low blood count)
- ❑ Asthma
- ❑ Cancer
- ❑ Chronic bronchitis, sinus or ear infections
- ❑ Chronic constipation
- ❑ Diabetes
- ❑ Drug or alcohol use/abuse
- ❑ Eating disorders
- ❑ Emotional/behavioral problems
- ❑ Head injury or concussion
- ❑ Heart murmur, heart problems, high blood pressure
- ❑ High lead level
- ❑ Kidney or bladder problems
- ❑ Learning problems
- ❑ Mental illness/depression
- ❑ Migraines
- ❑ Serious accident or emergency room visit
- ❑ Seizures
- ❑ Survived physical, emotional or sexual abuse
- ❑ Tuberculosis
- ❑ Vision, hearing, or speech problems
- ❑ Others not mentioned

Please explain any conditions checked_____

_____

_____

Family Medical History
Has a blood relative had the following conditions (the child's mother, father, brothers, sisters or grandparents)?

- ❑ Allergies/Asthma
- ❑ Birth Defect
- ❑ Bleeding Disorders
- ❑ Cancer
- ❑ Diabetes
- ❑ Drug or Alcohol use/abuse
- ❑ Glaucoma
- ❑ Heart Attacks/Disease
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Kidney Disease
- ❑ Lung Disease
- ❑ Mental Illness/Depression
- ❑ Migraines
- ❑ Obesity/Overweight
- ❑ Sickle Cell Anemia
- ❑ Seizures
- ❑ Stroke
- ❑ Thyroid Disease
- ❑ Tuberculosis
- ❑ Other
- ❑ Have any of your blood relatives died suddenly at less than 50 years of age of causes other than an accident or violence?

Please explain any conditions checked_____

_____

_____

Other pertinent family information_____

_____

_____

_____