

HEALTH QUESTIONNAIRE

Your Name _____ School _____

What School did you Attend Last Year _____

Do You Have any Chronic Health Conditions such as: asthma, diabetes, sickle cell disease, high blood pressure, back or joint pain etc.? (Yes / No) Please explain: _____

Have you ever had a severe allergic reaction (anaphylaxis) to a bee sting, or a food you have ingested such as nuts or strawberries etc.? Please explain: _____

Do you carry an inhaler for your asthma, or an epi-pen for your food or bee sting allergic? _____

Do you take any medications daily? (Yes/ No) Please list medications taken: _____

Have you ever been hospitalized? (Yes / No) What for? _____

Do you wear glasses or contact lenses for corrective vision? (Yes / No) _____

Do you wear a corrective device for hearing loss? (Yes / No) _____

What is the name of your health insurance, i.e., (Harvard Pilgrim, Tufts, Mass Health, Blue Cross Blue Shield etc.)? _____

What is the policy number on your insurance card? _____

What hospital and/or clinic do you go to for your healthcare? _____

What is your Doctor or Nurse Practitioner's Name? _____

What ethnicity are you, i.e., (Black, Asian, Latino, Caucasian, by-racial etc.)? _____