

Interval Health History for Athletics

Student Name:		DOB
School Name:		Age
Grade (check): <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12		Limitations: <input type="checkbox"/> NO <input type="checkbox"/> YES
Sport		Date of last Health Exam:
Sport Level: <input type="checkbox"/> Modified <input type="checkbox"/> Fresh <input type="checkbox"/> JV <input type="checkbox"/> Varsity		Date form completed:
MUST be completed and signed by Parent/Guardian - Give details to any YES answers on the last page.		

DOES OR HAS YOUR CHILD		
GENERAL HEALTH	NO	YES
Ever been restricted by a health care provider from sports participation for any reason?		
Ever had surgery?		
Ever spent the night in a hospital?		
Been diagnosed with mononucleosis within the last month?		
Have only one functioning kidney?		
Have a bleeding disorder?		
Have any problems with hearing or have congenital deafness?		
Have any problems with vision or only have vision in one eye?		
Have an ongoing medical condition?		
If yes, check all that apply:		
<input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Seizures <input type="checkbox"/> Sickle cell trait or disease <input type="checkbox"/> Other:		
Have Allergies?		
If yes, check all that apply		
<input type="checkbox"/> Food <input type="checkbox"/> Insect Bite <input type="checkbox"/> Latex <input type="checkbox"/> Medicine <input type="checkbox"/> Pollen <input type="checkbox"/> Other:		
Ever had anaphylaxis?		
Carry an epinephrine auto-injector?		
BRAIN/HEAD INJURY HISTORY	NO	YES
Ever had a hit to the head that caused headache, dizziness, nausea, confusion, or been told they had a concussion?		
Receive treatment for a seizure disorder or epilepsy?		
Ever had headaches with exercise?		
Ever had migraines?		

DOES OR HAS YOUR CHILD		
BREATHING	NO	YES
Ever complained of getting extremely tired or short of breath during exercise?		
Use or carry an inhaler or nebulizer?		
Wheeze or cough frequently during or after exercise?		
Ever been told by a health care provider they have asthma or exercise-induced asthma?		
DEVICES / ACCOMMODATIONS	NO	YES
Use a brace, orthotic, or another device?		
Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)?		
Wear protective eyewear, such as goggles or a face shield?		
Wear a hearing aid or cochlear implant?		
Let the coach/school nurse know of any device used. Not required for contact lenses or eyeglasses.		
DIGESTIVE (GI) HEALTH	NO	YES
Have stomach or other GI problems?		
Ever had an eating disorder?		
Have a special diet or need to avoid certain foods?		
Are there any concerns about your child's weight?		
INJURY HISTORY	NO	YES
Ever been unable to move their arms or legs or had tingling, numbness, or weakness after being hit or falling?		
Ever had an injury, pain, or swelling of a joint that caused them to miss practice or a game?		
Have a bone, muscle, or joint that bothers them?		
Have joints that become painful, swollen, warm, or red with use?		
Ever been diagnosed with a stress fracture?		

Student Name:		DOB:	
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DOES OR HAS YOUR CHILD		
HEART HEALTH		
Ever complained of:		
Ever had a test by a health care provider for their heart (e.g., EKG, echocardiogram, stress test)?		
Lightheadedness, dizziness, during or after exercise?		
Chest pain, tightness, or pressure during or after exercise?		
Fluttering in the chest, skipped heartbeats, heart racing?		
DOES OR HAS YOUR CHILD		
Ever been told by a health care provider		
They have or had a heart or blood vessel problem?		
If yes, check all that apply:		
<input type="checkbox"/> Chest Tightness or Pain	<input type="checkbox"/> Heart infection	
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Murmur	
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Low Blood Pressure	
<input type="checkbox"/> New fast or slow heart rate	<input type="checkbox"/> Kawasaki Disease	
<input type="checkbox"/> Has implanted cardiac defibrillator (ICD)		
<input type="checkbox"/> Has a pacemaker		
<input type="checkbox"/> Other:		

DOES OR HAS YOUR CHILD		
FEMALES ONLY		
Have regular periods?	No	Yes
MALES ONLY		
Have only one testicle?	No	Yes
Have groin pain or a bulge, or a hernia?		
SKIN HEALTH		
Currently have any rashes, pressure sores, or other skin problems?	No	Yes
Ever had a herpes or MRSA skin infection?		
COVID-19 INFORMATION		
Has your child ever tested positive for COVID-19?		
If NO, STOP. Go to Family Heart Health History. If YES, answer questions below:		
Date of positive COVID test:		
Was your child symptomatic?		
Did your child see a health care provider for their COVID-19 symptoms?		
Was your child hospitalized for COVID?		
Was your child diagnosed with Multisystem Inflammatory Syndrome (MISC)?		

FAMILY HEART HEALTH HISTORY	
A relative has/had any of the following: Check all that apply:	
<input type="checkbox"/> Enlarged Heart/ Hypertrophic Cardiomyopathy/ Dilated Cardiomyopathy	<input type="checkbox"/> Brugada Syndrome?
<input type="checkbox"/> Arrhythmogenic Right Ventricular Cardiomyopathy?	<input type="checkbox"/> Catecholaminergic Ventricular Tachycardia?
<input type="checkbox"/> Heart rhythm problems: long or short QT interval?	<input type="checkbox"/> Marfan Syndrome (aortic rupture)?
	<input type="checkbox"/> Heart attack at age 50 or younger?
	<input type="checkbox"/> Pacemaker or implanted cardiac defibrillator (ICD)?
A family history of:	
<input type="checkbox"/> Known heart abnormalities or sudden death before age 50?	<input type="checkbox"/> Structural heart abnormality, repaired or unrepaired?
<input type="checkbox"/> Unexplained fainting, seizures, drowning, near drowning, or car accident before age 50?	

If you answered NO to all questions, STOP. Sign and date below. GO to page 3 if you answered YES to a question.	
Parent/Guardian Signature:	Date:

Student Name:		DOB:	
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If you answered **YES** to any questions give details. Sign and date below.

Parent/Guardian Signature:	Date:
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