

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.

SINCE YOUR CHILD'S LAST HEALTH EXAM – HAS YOUR CHILD?		
GENERAL HEALTH	NO	YES
Been restricted by a health care provider from sports participation for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
Had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
Spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>
Been diagnosed with mononucleosis within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
Has only one functioning kidney?	<input type="checkbox"/>	<input type="checkbox"/>
Has or had a bleeding disorder?	<input type="checkbox"/>	<input type="checkbox"/>
Having problems with hearing or have congenital deafness?	<input type="checkbox"/>	<input type="checkbox"/>
Having problems with vision or only have vision in one eye?	<input type="checkbox"/>	<input type="checkbox"/>
Been diagnosed with a new medical condition?	<input type="checkbox"/>	<input type="checkbox"/>
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:		
Developed Allergies?	<input type="checkbox"/>	<input type="checkbox"/>
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"/> Other: <input type="checkbox"/> Pollen		
Had anaphylaxis?	<input type="checkbox"/>	<input type="checkbox"/>
Carry an epinephrine auto-injector?	<input type="checkbox"/>	<input type="checkbox"/>
Had or has groin pain, a bulge, or a hernia?	<input type="checkbox"/>	<input type="checkbox"/>
DEVICES / ACCOMMODATIONS	NO	YES
Uses a brace, orthotic, or another device?	<input type="checkbox"/>	<input type="checkbox"/>
Has special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
Wears protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>
Wears a hearing aid or cochlear implant?	<input type="checkbox"/>	<input type="checkbox"/>
Let the coach/school nurse know of any device used. Not required for contact lenses or eyeglasses.		

SINCE YOUR CHILD'S LAST HEALTH EXAM – HAS YOUR CHILD?		
BRAIN/HEAD INJURY HISTORY	NO	YES
Has or had a hit to the head that caused headache, dizziness, nausea, or confusion, or been told they had a concussion?	<input type="checkbox"/>	<input type="checkbox"/>
Received treatment for a seizure disorder or epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>
Has or had headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Has or had migraines?	<input type="checkbox"/>	<input type="checkbox"/>
BREATHING	NO	YES
Complained of getting extremely tired or short of breath during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Used or carries an inhaler or nebulizer?	<input type="checkbox"/>	<input type="checkbox"/>
Has or had wheezing or coughing frequently during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Been told by a health care provider they have asthma or exercise-induced asthma?	<input type="checkbox"/>	<input type="checkbox"/>
DIGESTIVE (GI) HEALTH	NO	YES
Has or had stomach or other GI problems?	<input type="checkbox"/>	<input type="checkbox"/>
Has an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
Has a special diet or need to avoid certain foods?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have concerns about your child's weight?	<input type="checkbox"/>	<input type="checkbox"/>
INJURY HISTORY	NO	YES
Been unable to move their arms or legs or had tingling, numbness, or weakness after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
Had an injury, pain, or joint swelling caused them to miss practice or a game?	<input type="checkbox"/>	<input type="checkbox"/>
Has or had a bone, muscle, or joint that bothers them?	<input type="checkbox"/>	<input type="checkbox"/>
Has or had joints that become painful, swollen, warm, or red with use?	<input type="checkbox"/>	<input type="checkbox"/>
Been diagnosed with a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>
FEMALES ONLY	NO	YES
Change in period frequency related to female athlete triad?	<input type="checkbox"/>	<input type="checkbox"/>

Student Name:	DOB:
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SINCE YOUR CHILD'S LAST HEALTH EXAM – HAS YOUR CHILD?		
MALES ONLY	NO	YES
Has only one testicle?	<input type="checkbox"/>	<input type="checkbox"/>
SKIN HEALTH	NO	YES
Has any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
Has a herpes or MRSA skin infection?	<input type="checkbox"/>	<input type="checkbox"/>
COVID-19 INFORMATION	NO	YES
Child tested positive for COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
IF NO, STOP and go to Family Heart Health History. If YES , answer the questions below:		
Date of positive COVID test:		
Was your child symptomatic?	<input type="checkbox"/>	<input type="checkbox"/>
Did your child see a healthcare provider for their COVID-19 symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
Was your child hospitalized for COVID?	<input type="checkbox"/>	<input type="checkbox"/>
Was your child diagnosed with Multisystem Inflammatory Syndrome (MISC)?	<input type="checkbox"/>	<input type="checkbox"/>

SINCE YOUR CHILD'S LAST HEALTH EXAM – HAS YOUR CHILD?		
HEART HEALTH	NO	YES
Had a test by a health care provider for their heart (e.g., EKG, echocardiogram, stress test)?	<input type="checkbox"/>	<input type="checkbox"/>
Has or had lightheadedness or dizziness during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Has or had chest pain, tightness, or pressure during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Has or had fluttering in the chest, skipped heartbeats, heart racing?	<input type="checkbox"/>	<input type="checkbox"/>
Been told by a healthcare provider they have or had a heart or blood vessel problem?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, check all that apply:		
<input type="checkbox"/> Chest Tightness or Pain	<input type="checkbox"/> Heart Infections	
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Murmur	
<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> High Cholesterol	
<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"/> Had a pacemaker implanted		
<input type="checkbox"/> Other:		

SINCE YOUR CHILD'S LAST HEALTH EXAM - CHECK ANY NEW FAMILY HEART HEALTH HISTORY
A relative had or is currently experiencing 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"/> Structural heart abnormality, repaired or unrepaired? <input type="checkbox"/> Heart attack at age 50 or younger?
<input type="checkbox"/> Known heart abnormalities or sudden death before age 50? <input type="checkbox"/> Pacemaker or implanted cardiac defibrillator (ICD)?
<input type="checkbox"/> Unexplained fainting, seizures, drowning, near drowning, or car accident before age 50?

If you answered NO to <u>all</u> questions, STOP . Sign and date below.	
GO to page 3 if you answered YES to a question.	
<input type="checkbox"/> Information on this form is <u>NEW</u> information since my child's last health examination.	
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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