

Interval Health History for Athletics

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|---|--|---|
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| Ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| Ever 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"/> |
| Have only one functioning kidney? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have a bleeding disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have any problems with hearing or have congenital deafness? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have any problems with vision or only have vision in one eye? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have an ongoing 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: | | |
| Have 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"/> Pollen <input type="checkbox"/> Other: | | |
| Ever had anaphylaxis? | <input type="checkbox"/> | <input type="checkbox"/> |
| Carry an epinephrine auto-injector? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| Receive treatment for a seizure disorder or epilepsy? | <input type="checkbox"/> | <input type="checkbox"/> |
| Ever had headaches with exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| Ever had migraines? | <input type="checkbox"/> | <input type="checkbox"/> |

| DOES OR HAS YOUR CHILD | | |
|--|--------------------------|--------------------------|
| BREATHING | NO | YES |
| Ever complained of getting extremely tired or short of breath during exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| Use or carry an inhaler or nebulizer? | <input type="checkbox"/> | <input type="checkbox"/> |
| Wheeze or cough frequently during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| Ever been told by a health care provider they have asthma or exercise-induced asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| DEVICES / ACCOMMODATIONS | NO | YES |
| Use a brace, orthotic, or another device? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)? | <input type="checkbox"/> | <input type="checkbox"/> |
| Wear protective eyewear, such as goggles or a face shield? | <input type="checkbox"/> | <input type="checkbox"/> |
| Wear 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. | | |
| DIGESTIVE (GI) HEALTH | NO | YES |
| Have stomach or other GI problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| Ever had an eating disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have a special diet or need to avoid certain foods? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are there any concerns about your child's weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| INJURY HISTORY | NO | YES |
| Ever 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"/> |
| Ever had an injury, pain, or swelling of a joint that caused them to miss practice or a game? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have a bone, muscle, or joint that bothers them? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have joints that become painful, swollen, warm, or red with use? | <input type="checkbox"/> | <input type="checkbox"/> |
| Ever been diagnosed with a stress fracture? | <input type="checkbox"/> | <input type="checkbox"/> |

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|---------------|--|------|--|
| Student Name: | | DOB: | |
|---------------|--|------|--|

| DOES OR HAS YOUR CHILD | | |
|---|---|--------------------------|
| HEART HEALTH | No | YES |
| Ever complained of: | | |
| Ever had a test by a health care provider for their heart (e.g., EKG, echocardiogram, stress test)? | <input type="checkbox"/> | <input type="checkbox"/> |
| Lightheadedness, dizziness, during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| Chest pain, tightness, or pressure during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| Fluttering in the chest, skipped heartbeats, heart racing? | <input type="checkbox"/> | <input type="checkbox"/> |
| Ever been told by a health care 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 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 | No | YES |
| Have regular periods? | <input type="checkbox"/> | <input type="checkbox"/> |
| MALES ONLY | No | YES |
| Have only one testicle? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have groin pain or a bulge, or a hernia? | <input type="checkbox"/> | <input type="checkbox"/> |
| SKIN HEALTH | No | YES |
| Currently have any rashes, pressure sores, or other skin problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| Ever had a herpes or MRSA skin infection? | <input type="checkbox"/> | <input type="checkbox"/> |
| COVID-19 INFORMATION | | |
| Has your child ever tested positive for COVID-19? | <input type="checkbox"/> | <input type="checkbox"/> |
| If NO, STOP. Go to Family Heart Health History. If YES, answer questions below: | | |
| Date of positive COVID test: | | |
| Was your child symptomatic? | <input type="checkbox"/> | <input type="checkbox"/> |
| Did your child see a health care 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"/> |

| 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? | |

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

Student
Name:

DOB:

If you answered **YES** to any questions give details. Sign and date below.

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Parent/Guardian
Signature:

Date: