

Interval Health History for Athletics	
Student Name:	DOB:
Grade (check): <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 Annual Physician's Health Exam:
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"/>

Student Name:		DOB:	
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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"/>
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?	

<p>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.</p>	
Parent/Guardian Signature:	Date:

Student
Name:

DOB:

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

Parent/Guardian
Signature:

Date: