NYSED Interval Health History for Athletics

Student Name:	DOB:
Grade (check): ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12	SPORT:
Sport Level: ☐ Modified ☐ Fresh ☐ JV ☐ Varsity	Date of last physical:

MUST be completed and signed by Parent/Guardian - Give details to any YES answers on the last page.

GENERAL HEALTH	NO	YES
Been restricted by a health care provider from sports?		
Been diagnosed with mononucleosis within the last month?	☐	☐
Ever had surgery?		
Ever spent the night in hospital?		
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: ☐ Asthma ☐ Diabetes ☐ Seizures ☐ Sickle cell trait or disease ☐ Other:		
Have Allergies?	☐	☐
If yes, check all that apply ☐ Food ☐ Insect Bite ☐ Latex ☐ Medicine ☐ Pollen ☐ Other:		
Ever had anaphylaxis?	☐	☐
Carry an epinephrine auto-injector?	☐	☐
Ever had an eating disorder?		

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 any unexplained seizures?	☐	☐
Ever had migraines?	☐	☐

INJURY HISTORY	NO	YES
Ever been unable to move arm/leg or had tingling, numbness, or weakness after being hit or falling?	☐	☐
Have joints become painful, swollen, warm, or red with use?	☐	☐
Been diagnosed with a stress fracture?		

DEVICES / ACCOMMODATIONS	NO	YES
Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)?	☐	☐
Wear protective eyewear?	☐	☐

BREATHING	☐	☐
Use or carry an inhaler/nebulizer?	☐	☐
Wheeze or cough frequently during or after exercise?	☐	☐
Been told by a health care provider they have asthma or exercise induced asthma?		
Get extremely tired or short of breath while exercising?		

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?	☐	☐
Ever been told by a health care provider they have or had a heart or blood vessel problem?	☐	☐
If yes, check all that apply: ☐ Chest Tightness or Pain ☐ Heart infection ☐ High Blood Pressure ☐ Heart Murmur ☐ High Cholesterol ☐ Low Blood Pressure ☐ New fast or slow heart rate ☐ Kawasaki Disease ☐ Has implanted cardiac defibrillator (ICD) ☐ Has a pacemaker ☐ Other:		

FEMALES ONLY	NO	YES
Have regular periods?	☐	☐
Age period began?		

MALES ONLY	NO	YES
Have only one testicle?	☐	☐
Have groin pain or a bulge, or a hernia?	☐	☐

SKIN HEALTH	NO	YES
Currently have any rashes, pressure sores, or other skin problems?	☐	☐
Ever had herpes or MRSA skin infection?	☐	☐

COVID-19 INFORMATION		
Has your child ever tested positive for COVID-19?	☐	☐
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:

☐ Enlarged Heart/ Hypertrophic Cardiomyopathy/ Dilated Cardiomyopathy

☐ Arrhythmogenic Right Ventricular Cardiomyopathy?

☐ Heart rhythm problems, long or short QT interval?

☐ Brugada Syndrome?

☐ Catecholaminergic Ventricular Tachycardia?

☐ Marfan Syndrome (aortic rupture)?

☐ Heart attack at age 50 or younger?

☐ Pacemaker or implanted cardiac defibrillator (ICD)?

A family history of:

☐ Known heart abnormalities or sudden death before age 50?

☐ Structural heart abnormality, repaired or unrepaired?

☐ Unexplained fainting, seizures, drowning, near drowning, or car accident before age 50?

If you answered **NO** to ***all*** questions, **STOP**. Sign and date below.
If you answered **YES** to a question please explain below.

Parent/Guardian Signature:	Date:

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

Parent Signature _____ Date _____