

## 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:  |
| <b>MUST be completed and signed by Parent/Guardian - Give details to any YES answers on the last page.</b>  |  |   |

| 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<br><input type="checkbox"/> Seizures <input type="checkbox"/> Sickle cell trait or disease<br><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<br><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?  |    |     |
| <b>Let the coach/school nurse know of any device used. Not required for contact lenses or eyeglasses.</b>      |    |     |
| 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: |  |
|---------------|--|------|--|

| DOES OR HAS YOUR CHILD  |   |  |
|---|---|--|
| <b>HEART HEALTH</b>   |   |  |
| 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?  |   |  |
| <b>DOES OR HAS YOUR CHILD</b>   |   |  |
| 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   |    |     |
|--|----|-----|
| <b>FEMALES ONLY</b>  |    |     |
| Have regular periods?  | No | Yes |
| <b>MALES ONLY</b>  |    |     |
| Have only one testicle?  | No | Yes |
| Have groin pain or a bulge, or a hernia?   |    |     |
| <b>SKIN HEALTH</b>   |    |     |
| Currently have any rashes, pressure sores, or other skin problems?                               | No | Yes |
| Ever had a herpes or MRSA skin infection?  |    |     |
| <b>COVID-19 INFORMATION</b>  |    |     |
| Has your child ever tested positive for COVID-19?  |    |     |
| If <b>NO, STOP.</b> Go to Family Heart Health History.<br>If <b>YES,</b> 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:<br>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 <b>NO</b> to <b>all</b> questions, <b>STOP.</b> Sign and date below.<br/> <b>GO</b> to page 3 if you answered <b>YES</b> to a question.</p> |       |
| Parent/Guardian Signature:   | Date: |

