Health History Form (to be completed for each student by the parent/guardian)

Date __________ Student’s Name __________ Date of birth __________

Gender _______ Age _______ Grade _______ School __________

Medicines: Please list all of the prescription and over-the-counter medicines and supplements (herbal & nutritional) that the student is currently taking.

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.

☐ Medicines (Please list) ☐ Pollens ☐ Food ☐ Stinging Insects

Explain “Yes” answers below. Circle questions you don’t know the answers to.

<table>
<thead>
<tr>
<th>GENERAL QUESTIONS</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

1. Has a doctor ever denied or restricted your participation in sports for any reason?
2. Do you have any ongoing medical conditions? If so, please identify below:
   - Asthma
   - Anemia
   - Diabetes
   - Infections
   Other: __________
3. Have you ever spent the night in the hospital?
4. Have you ever had surgery?
5. Have you ever passed out or nearly passed out DURING OR AFTER exercise?
6. Have you ever had any discomfort, pain, tightness, or pressure in your chest during exercise?
7. Does your heart ever race or skip beats (irregular beats) during exercise?
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply:
   - High blood pressure
   - A heart murmur
   - High cholesterol
   - A heart infection
   - Kawasaki disease
   Other: __________
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)
10. Do you get lightheaded or feel more short of breath than expected during exercise?
11. Have you ever had an unexplained seizure?
12. Do you get more tired or short of breath more quickly than your friends during exercise?

<table>
<thead>
<tr>
<th>HEART HEALTH QUESTIONS ABOUT YOUR FAMILY</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident or sudden infant death syndrome)?
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, aneurysmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome or catecholaminergic polymorphic ventricular tachycardia?
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?
16. Has anyone in your family had unexplained fainting or unexplained seizures?

<table>
<thead>
<tr>
<th>BONE AND JOINT QUESTIONS</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?
18. Have you ever had any broken or fractured bones or dislocated joints?
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?
20. Have you ever had a stress fracture?
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)
22. Do you regularly use a brace, orthotics, or other assistive device?
23. Do you have a bone, muscle, or joint injury that bothers you?
24. Do any of your joints become painful, swollen, feel warm or look red?
25. Do you have any history of juvenile arthritis or connective tissue disease?

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Parent/Guardian __________ Date __________

©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted to reprint for noncommercial, educational purposes with acknowledgement.