# Health History
# (Seventh Grade through High School)

Student Name:_____ Date of Birth:_____ Sex: M ☐ F ☐

Parent/Guardian Name:_____ Parent/Guardian Telephone:_____

**Please check for all that apply. Explain "yes" answers below.**

| | Y | N |
|---|---|---|
| 1. Has there been a medical illness or injury since the last checkup or sports physical? | ☐ | ☐ |
| 2. Is the student currently taking any prescribed medication or over-the-counter medication (please list all medications)? | ☐ | ☐ |
| 3. Does the student have any allergies? What kind of reaction does the student develop? | ☐ | ☐ |
| 4. Has the student ever have difficulty breathing, chest pain, dizziness, etc. during or after exercising? | ☐ | ☐ |
| Does the student have any heart conditions (heart murmur, cardiomyopathy, Marfan Syndrome,etc.)? | ☐ | ☐ |
| Has a physician ever denied or restricted participation on sports for any heart problems? | ☐ | ☐ |
| 5. Does the student cough, wheeze or have trouble breathing during or after activity? | ☐ | ☐ |
| Does the student have any respiratory conditions including asthma? | ☐ | ☐ |
| Does the student have seasonal allergies that require medical treatment? | ☐ | ☐ |
| Does the child have any chronic conditions including mental or behavioral health diagnoses? | ☐ | ☐ |
| Does your student currently use any tobacco products, including vapes or e-cigarettes? | ☐ | ☐ |

If "Yes," would you be interested in receiving information and resources to help them quit?

- ☐ Yes I would like to receive information
- ☐ No, I am not interested
- ☐ I'd like to know more about what support is available

| | Y | N |
|---|---|---|
| 6. Has the student ever had a head injury or concussion? | ☐ | ☐ |
| Has the student ever had a head injury, become unconscious or lost their memory? | ☐ | ☐ |
| Has the student ever had a seizure? | ☐ | ☐ |
| Does the student have frequent or severe headaches? | ☐ | ☐ |
| Does the student ever have numbness or tingling in arms, hands, legs, or feet? | ☐ | ☐ |
| Has the student ever had a nerve injury? | ☐ | ☐ |
| 7. Has the student ever become ill from exercising in the heat? | ☐ | ☐ |
| 8. Has the student had any problems with their eyes or vision? | ☐ | ☐ |
| 9. Has the student ever had a sprain, strain, or swelling after injury? | ☐ | ☐ |
| Has the student broken or fractured any bones or dislocated any joints? | ☐ | ☐ |
| Has the student had any other problems with pain or swelling in muscles, tendons, bones or joints? | ☐ | ☐ |
| 10. Does the student have any current skin problems (for example- itching, rashes, acne, warts, fungus or blisters)? | ☐ | ☐ |
| 11. Has your student ever expressed symptoms of depression, stress, anxiety, dislike of body image? | ☐ | ☐ |

Check all that apply.

☐Head ☐Elbow ☐Thigh ☐Neck
☐Forearm ☐Knee ☐Back ☐Wrist
☐Shin/Calf ☐Chest ☐Hand ☐Ankle
☐Shoulder ☐Finger ☐Foot ☐Hip
☐Upper Arm

Explain "yes" answers here: