



Health History Questionnaire

This questionnaire must be completed before your Physical Exam (age > 6years) or before your physician can sign any activity/camp/sports forms.

Name of child _____

Birthdate _____

Circle Yes or No to the following questions. **Explain** all 'Yes' responses in the space provided (to the right).

1. Injury or illness since last checkup? -----Yes/No _____
2. Strain, sprain, fracture, joint pain or swelling?-----Yes/No _____
3. Chronic illnesses, hospitalization or surgeries?-----Yes/No _____
4. Allergies to medications, insects or food?-----Yes/No _____
5. Any medications or supplements of any type?-----Yes/No _____
6. Ever restricted from sports/activity by a physician?-----Yes/No _____
7. Dizziness, passed out, chest pain with exercise/activity?-Yes/No _____
8. Concussion, "knocked out", unconsciousness,
memory loss, seizure?----- Yes/No _____
9. Problems while exercising in the heat?-----Yes/No _____
10. Stinger, burner, pinched nerve: numbness or
tingling in arms, hands, legs, or feet?-----Yes/No _____
11. Severe/frequent headache? Neck pain?-----Yes/No _____
12. Any skin problems?-----Yes/No _____
13. History of sudden death in a close relative <50 yrs old?---Yes/No _____
14. History of high blood pressure or heart murmur?-----Yes/No _____
15. Asthma, allergies, wheezing, difficulty breathing?-----Yes/No _____
16. Glasses, contacts, vision or eye problems?-----Yes/No _____
17. Girls: any concerns regarding periods?-----Yes/No _____

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With my signature, I state that, to the best of my knowledge, the above answers are correct.

Signature of Parent or Legal Guardian, or Patient 18 years of age or older:

Signature _____

Date _____

Office use only
Provider's initials _____
Date reviewed _____