HEALTH HISTORY QUESTIONNAIRE

Code: ________________________________ Test Date: __________

Sex: M F Age: __________ Height: ________________ Weight:______________

ALLERGIES: ____

____

GENERAL MEDICAL HISTORY

Has your child had any of the following medical problems? If so, please place a (x) in the box next to it.

HEART
- □ Murmur
- □ Palpitations
- □ Irregular beats
- □ Chest pain / angina
- □ High blood pressure
- □ Heart failure
- □ Heart attack
- □ Heart surgery
- □ Ankle swelling
- □ Poor circulation

LUNG
- □ Recent cold
- □ Chronic cough
- □ Asthma
- □ Emphysema / COPD
- □ Difficulty breathing
- □ Shortness of breath
- □ Pneumonia
- □ Tuberculosis
- □ Sleep apnea
- □ Use CPAP / home oxygen / nebulizer

NERVE
- □ Dizziness
- □ Seizures
- □ Stroke or TIA
- □ Paralysis
- □ Multiple Sclerosis
- □ Fainting Spells

SKIN
- □ Rash
- □ Itching
- □ Night Sweats
- □ Cuts
- □ Abrasions
- □ Bruises
- □ Body Piercing

GASTRONINTESTINAL
- □ Recent nausea, vomiting
- □ Persistent diarrhea
- □ Black tarry stools
- □ Constipation
- □ Blood in stool
- □ Hiatal hernia
- □ Reflux / indigestion
- □ Ulcer

GENITOURINARY
- □ Difficulty urinating
- □ Burning with urination
- □ Blood in urine
- □ Frequency / urgency
- □ Incontinence
- □ Kidney stones
- □ Kidney disease
- □ Catheter

MUSCLE / JOINTS
- □ Weakness
- □ Numbness
- □ Muscle cramps
- □ Arthritis
- □ Neck Injury / surgery
- □ Back injury / surgery

OTHER
- □ Diabetes
- □ Hepatitis A B C
- □ Bleed easily
- □ Exposure to HIV / AIDS
- □ Anemia
- □ Liver diseases
- □ Thyroid
- □ Blood clot

NEUROLOGICAL
- □ Development delay
- □ Learning disability
- □ Black tarry stool
- □ ADD / ADHD

IMMUNIZATION
- □ Up to date
- □ Unknown

NURTRITION
- □ Breast fed
- □ Bottle fed
- □ Table fed

HEAD AND NECK
- □ Nosebleeds
- □ Abnormal drainage
- □ Ear tubes

CURRENT MEDICATIONS

Please list all medications your child is taking or has recently taken:

Medication *Dose* *Reason*

____

____

____

____

____

____

OTHER MEDICAL HISTORY

Please list any other medical conditions or concerns that may affect your child's exercise program.
____
____

Does your child have any metal implants or implanted device such as pacemaker, defibrillator, shunt, or vagal stimulator?
☐ Yes ☐ No If Yes please describe ____
____
____

Did your child reach puberty?
☐ Yes ☐ No <u>Females:</u> If Yes please report the date of the last menstrual period_____________
______________________________ and the date of menarche _____________________________

If you know your child's Tanner stage or peak height velocity, please report it here:_____________
____

The information that is obtained during my participation in this program will be treated as privileged and confidential. I declare that information provided on this health history questionnaire is true and accurate to the best of my information, knowledge, and belief.

Parent Signature: ______________________________ Date: __________________