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

GASTRONTESTINAL
- 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

NUTRITION
- 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:

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<tr>
<th>Medication</th>
<th>Dose</th>
<th>Reason</th>
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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  Females: If Yes please report the date of the last menstrual period________________________
__________________________________________________________________________________
__________________________________________________________________________________

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: ___________________