*Sherburne-Earlville Middle/High School Health Office*

# HEALTH HISTORY

*Phone: 674-7310/7314* *Fax: 674-7383*

***TO BE COMPLETED, SIGNED BY PARENT/GUARDIAN and RETURNED TO THE HEALTH OFFICE!***

**Name: _____ Date of Birth _____ Grade____**

**Date of last Physical Exam:**

*Please check the season(s) you intend to play a sport:*
☐ *Fall* ☐ *Winter* ☐ *Spring*

**ImPACT Test Date:**

☐ **Your child needs to have a *physical* for the upcoming sports season.**
◆ ***A current physical must be on file in the Health Office to be eligible to participate in sports.***

☐ According to New York State guidelines, **new entering students, 7th, 9th, and 11th grade students are required to have a physical.** Please complete and return this form to the Health Office. ***A current physical must be on file.***

☐ **Physical Fitness Certification for Employment** ***(Working papers request)***

***Parent*: *Please check (✓) one of the following:***

☐ **My child will have his/her physical with *primary health care provider.** Date of appointment_____**

☐ **My child will have a physical at the School Based Health Center (SBHC).* Date of appointment _____**

* ***A copy of the exam must be sent to the Health Office for the student's health file.***

☞ ☞ ☞ **Does your child have, or has he/she ever had:** ***(please check or circle where appropriate)***

| | Yes | No |
|---|---|---|
| Seasonal Allergies/ Hay Fever | ☐ | ☐ |
| **Allergy requiring EPIPEN? Bee, Food, Latex, Other** | ☐ | ☐ |
| **Asthma- uses an Inhaler?** | ☐ | ☐ |
| Anemia | ☐ | ☐ |
| Arthritis | ☐ | ☐ |
| Bladder / Kidney Problem or Injury | ☐ | ☐ |
| One kidney or one functioning kidney | ☐ | ☐ |
| Fainting Spells, dizziness, syncope | ☐ | ☐ |
| Bleeding disorder | ☐ | ☐ |
| **Ear Problems/** Hearing Loss/ Hearing Aid | ☐ | ☐ |
| Eye glasses/ Contact lens/ **Protective eye gear** | ☐ | ☐ |
| Eye Problems/ One Eye/ **Vision Loss** | ☐ | ☐ |
| Fractured nose | ☐ | ☐ |
| Nosebleeds, frequent or severe | ☐ | ☐ |
| Orthodontic device or braces | ☐ | ☐ |
| Chipped Tooth/ teeth, capped tooth/ teeth | ☐ | ☐ |
| Stomach Ulcer/stomach problems | ☐ | ☐ |
| Rashes, sores, or skin problems | ☐ | ☐ |
| Rheumatic Fever | ☐ | ☐ |
| **Food allergies?_____** | ☐ | ☐ |
| **Medication allergies?_____** | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| Mononucleosis (mono) Date: _____ | ☐ | ☐ |
| Heat cramp/ Heatstroke | ☐ | ☐ |
| Headaches (or headache with exercise?) | ☐ | ☐ |
| Hernia | ☐ | ☐ |
| **Heart Problem/** Murmur/ Chest Pains | ☐ | ☐ |
| Felt irregular heart beat, skipped beat, palpitations, fluttering, heart racing | ☐ | ☐ |
| Exercised induced chest pain/pressure | ☐ | ☐ |
| A pacemaker | ☐ | ☐ |
| EKG, stress test or echocardiogram | ☐ | ☐ |
| **A special diet or avoided certain foods** | ☐ | ☐ |
| A worry about his/her weight | ☐ | ☐ |
| Brace or orthotic device | ☐ | ☐ |
| **Diabetes** | ☐ | ☐ |
| Hypoglycemia | ☐ | ☐ |
| Injury to spleen | ☐ | ☐ |
| Convulsions/**Seizures/Epilepsy** | ☐ | ☐ |
| ***Males only***: Only One Testicle | ☐ | ☐ |
| Marfan Syndrome | ☐ | ☐ |
| Sickle cell trait or disease | ☐ | ☐ |
| Have a special device or prosthesis-insulin pump, glucose sensor, ostomy bag etc.? | ☐ | ☐ |

***Please see other side*** ➔

***Girls only:*** Age of onset of menstrual period _____ How many times in the past year? _____ Are periods regular? Yes ☐ No ☐

**Has a doctor ever told you that you have**: ☐ High or low blood pressure ☐ high cholesterol ☐ heart murmur ☐ heart infection

**Has your child ever had an injury like a sprain, strain, muscle or ligament tear, tendinitis, broken bone, stress fracture, a dislocated joint or any injury that required *x-rays, MRI, CT, surgery, physical therapy, a brace, a cast, crutches or a stay in the hospital*? If yes, check:**

☐ *Head* ☐ *Upper back* ☐ *Lower back* ☐ *Upper Arm* ☐ *Elbow* ☐ *Forearm* ☐ *Wrist* ☐ *Hand/fingers* ☐ *Chest*
☐ *Neck* ☐ *Shoulder* ☐ *Hip* ☐ *Thigh* ☐ *Knee* ☐ *Calf/shin* ☐ *Ankle* ☐ *Foot/toes*

| | Yes | No |
|---|---|---|
| Is your child, or has your child ever been assigned to the ***Adaptive Physical Education Program?*** _____ | ☐ | ☐ |
| **Has your child ever been restricted by a health care provider from PE/sports for any reason?** _____ | ☐ | ☐ |
| Has your child *ever* had an **illness, condition, or injury** that required him/her to go to the hospital, either as a patient overnight, or required an operation? If so, explain _____ | ☐ | ☐ |
| Has your child ever had an **operation** (surgery)? _____ | ☐ | ☐ |
| ***Has your child been unconscious or experienced memory loss from a blow to the head?*** _____ | ☐ | ☐ |
| ***Has your child ever been diagnosed with a head injury or concussion? (Date _____ )*** _____ | ☐ | ☐ |
| Has your child ever complained of **lightheadedness or dizziness** during or after exercise? _____ | ☐ | ☐ |
| Has your child had **severe cramping or illness** when exercising in the heat? _____ | ☐ | ☐ |
| Has your child ever complained of **chest pressure, shortness of breath, wheezing or coughing during or after exercise**? _____ | ☐ | ☐ |
| Has your child ever **fainted** during exercise? If so, explain: _____ | ☐ | ☐ |
| Has your child ever had **tingling, numbness, weakness** or unable to move his/her arms or legs after a hit or a fall? _____ | ☐ | ☐ |
| Has your child taken ***any medication in the past year****?* If so, explain: _____ | ☐ | ☐ |
| Is your child taking **any medication now?** If so, explain: _____ | ☐ | ☐ |
| Is your child under **medical care now**? _____ | ☐ | ☐ |
| Does your child have any ***learning or attention*** **problems?** _____ | ☐ | ☐ |
| Does your child have any ***behavior, emotional or mental health problems*****?** If so, explain: _____ | ☐ | ☐ |

**Family History:**

◆ Has there ever been a sudden death in a family member **under the age of fifty (50)**? ..... ☐ ☐
If so, explain: _____

◆ Does any **relative** have a serious illness? If so explain..... ☐ ☐

◆ Has any relative had the following, under the age of 55? ☐ **Asthma** ☐ **Diabetes** ☐ **Heart disease** ☐ **Stroke** ☐ **Marfan syndrome**
☐ **Cardiomyopathy** ☐ **Long QT or Short QT syndrome** ☐ **Brugada syndrome** ☐ catecholaminergic polymorphic ventricular tachycardia

◆Since your child's **last physical examination**, *has your child had any injury or medical illness?* ..... ☐ ☐
*If so, explain:* _____

◆***Do you have any worries about your child's health or other questions you would like to discuss with a doctor? .....*** ☐ ☐
*If so, explain:* _____

***To the best of my knowledge, the above statements are accurate.***

✦***Parent/Guardian*** **signature** _____ **Date**_____

❑ *I give permission for a physical exam to be done at the Bassett School Based Health Center (SBHC).*
Parent/Guardian may call 674-8416 to schedule this appointment...

✦***Parent/Guardian*** **signature**_____ **Date** _____