

Sports Participation Interim Questionnaire

Diablo Valley Pediatric Medical Group

The purpose of this form is an addendum to the previous Physical Exam or Sports Cardiovascular Screen in order to review any new or significant past health history information that has occurred **since the student's last Physical Examination**.

Interim Medical History (to be completed by student/parent/legal guardian)

Student's Name: _____

| | YES | NO | |
|-----|--------------------------|--------------------------|---|
| 1. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any illness/injury which required you to see a healthcare provider? |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any recurrent illness? |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | Were you hospitalized overnight? |
| 4. | <input type="checkbox"/> | <input type="checkbox"/> | Did you have surgery? |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any injuries requiring treatment by a physician? |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | Are you presently taking ANY medications, vitamins, or supplements? |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any chest pain, dizziness, fainting, passing out during or after exercise? |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | Do you tire more easily or quickly during exercise? |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any problem with your blood pressure or heart? |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had fainting, convulsions, seizures, or severe dizziness? |
| 11. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have frequent, severe headaches? |
| 12. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had a "stinger" or "burner" or "pinched nerve"? |
| 13. | <input type="checkbox"/> | <input type="checkbox"/> | Have you been "knocked out", had a concussion, or other head injury? |
| 14. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had a neck or head injury? |
| 15. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had heat exhaustion or heat stroke? |
| 16. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had asthma, or trouble breathing, or cough during or after exercise? |
| 17. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any problem with your eyes or vision? |
| 18. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any injuries to your knee? |
| 19. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any injuries to your ankle? |
| 20. | <input type="checkbox"/> | <input type="checkbox"/> | Have you injured any other joint (shoulder, wrist, fingers, etc) or have loose joints? |
| 21. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had a broken bone (fracture)? |
| 22. | <input type="checkbox"/> | <input type="checkbox"/> | Have any relatives had heart problems, heart attack, or sudden death? |
| 23. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any medical concerns about participating in your sport? |

Examiner's Comments on All "YES" Answers (refer to question number):

Date: _____ Parent/Guardian Signature: _____

Date: _____ Physician/NP Signature: _____