Pediatrics Associates

450 Veterans Memorial Parkway, Building 10, E Prov., RI 02914 (401) 438-6888

Sports Health History Questionnaire

Name _____ Date _____

Age _____ Grade _____

Sports _____

1. Chest pain with exercise?	Yes _____	No _____
2. Dizziness or fainting during or after exercise?	Yes _____	No _____
3. Has any family member died suddenly at less than 40 years of age of causes other than an accident?	Yes _____	No _____
4. Has any family member had a heart attack at less than 55 years of age?	Yes _____	No _____
5. Have you had a seizure, concussion or been unconscious for any reason in the last year?	Yes _____	No _____
6. During the last 12 months have you had any major medical problems?	Yes _____	No _____
7. During the last 12 months have you had any athletic injury?	Yes _____	No _____
8. Do you have any severe allergies (bee stings or medicine) and/or asthma?	Yes _____	No _____
9. Do you take any medication or dietary supplements that relate to athletics?	Yes _____	No _____