Child Medical History Form

GENERAL INFORMATION

CHILD Name: Date of Birth:
Parent's Name:
Address:
City: State: Zip: Email:
Phone-home: ( ) cell: ( ) work: ( )
Child's Age: Sex: Height: Weight:
Child's Physician: Office Phone: ( )
Insurance Carrier: Phone No: ( )

PLEASE RESPOND TO ALL QUESTIONS BELOW FOR CHILD NAMED ABOVE:

Has your Child's doctor ever said your Child has any cardiovascular problems?	Yes	No
Does your Child frequently suffer from chest pains?	Yes	No
Has your Child ever had a heart attack?	Yes	No
Does your Child ever experience an irregular or racing heart rate during exercise or at rest?	Yes	No
Does your Child often feel faint or have spells of severe dizziness?	Yes	No
Has a doctor ever said that your Child's blood pressure is too high?	Yes	No
Does your Child often have difficulty breathing?	Yes	No
Has a doctor ever told you that your Child has a bone or joint problem such as arthritis that has been aggravated by exercise, or might be aggravated with exercise?	Yes	No
Is there a good physical reason not mentioned here why your Child should not follow an activity program even if you wanted to?	Yes	No
If yes list:		
Is your Child not accustomed to vigorous exercise?	Yes	No
Is your Child diabetic?	Yes	No
Date of Child's last physician visit:		

List any medications your Child is now taking and the reason for which they were prescribed:	
Describe the condition:	
List any surgical procedures your Child has undergone:	
Has your Child received physical therapy or chiropractic care?	
Has your Child or any member of his/her immediate family (mother, father, sister or	
brother) been diagnosed with:	Heart Disease:
Diabetes:	Hypertension:
Stroke:	High Cholesterol:
Obesity:	Hyperthyroidism:
How many times per week does your Child engage in moderate or strenuous exercise for at least 30 minutes? 1 2 3 4 5 >5	
Does your Child have any pain when exercising? If yes, rate on a scale of 1–10.	
Does your child have any condition that may create social interaction difficulties? Yes No If yes please provide specific information:	
Does your Child have any allergies? Yes No If yes please list all allergies.	
Does your child have Diabetes. Yes No If yes please describe type and details.	
Have you ever been diagnosed with a heart murmur? If yes what kind?	
Signature:_____ **Date:_____**	
In case of emergency, notify the following person:	

Name:		Phone:	Home	
Address:			Work	
City: State: Zip:			Cell	

For Staff only:
Reviewed by HOOPS Staff by _____ Date:_____
Notes: