Allegro PEDIATRICS

For Office Use
Provider's Initials: _____

HEALTH HISTORY QUESTIONNAIRE

This questionnaire must be completed before your physical exam or before your provider can sign any activity/camp/sports forms.

Name of Child:_____ Date of Birth:_____

Check "YES," "NO," or "UNSURE" for the following questions. Explain all "YES" responses in the space provided below.

	YES	NO	UNSURE
1. Injury or illness since last checkup?	☐	☐	☐
2. Have you ever had confirmed or suspected COVID-19 infection? *(If **YES**, please answer a.-c.)*	☐	☐	☐
a. Did you have 4 or more days of fever, significant muscle aches/fatigue?	☐	☐	☐
b. Were you hospitalized?	☐	☐	☐
c. Are you experiencing any chest pain, shortness of breath, dizziness with exercise, new heart palpitations, or new fainting?	☐	☐	☐
3. Any medications or supplements of any type? (List with dosage)	☐	☐	☐
4. Allergies to medications, insects, or food?	☐	☐	☐
5. Passed out or nearly passed out DURING or AFTER exercise?	☐	☐	☐
6. Chest discomfort, pain, tightness, or pressure during exercise?	☐	☐	☐
7. Heart races or skips beats (irregular beats) during exercise?	☐	☐	☐
8. Light-headed or more short of breath than expected during exercise?	☐	☐	☐
9. Heart problem such as high blood pressure, high cholesterol, Kawasaki disease, heart murmur, or heart infection?	☐	☐	☐
10. Test for the heart ordered by a doctor (e.g., EKG or echocardiogram)?	☐	☐	☐
11. Unexplained seizure?	☐	☐	☐
12. Family member died of heart problems or sudden death before age 50?	☐	☐	☐
13. Family history of hypertrophic cardiomyopathy, arrythmogenic right ventricular cardiomyopathy, Marfan, long QT, or Brugada syndrome?	☐	☐	☐
14. Family member with heart problem, pacemaker, or implanted defibrillator?	☐	☐	☐
15. Family member with unexplained fainting, seizures, or near drowning?	☐	☐	☐
16. Ever restricted from sports by a physician?	☐	☐	☐
17. Concussion, knocked out, memory loss, or severe/frequent headache?	☐	☐	☐
18. Stinging, burning, pinched nerve, numbness or tingling in extremities?	☐	☐	☐
19. Problems while exercising in the heat?	☐	☐	☐
20. Any skin problems?	☐	☐	☐
21. Asthma, allergies, wheezing, or difficulty breathing?	☐	☐	☐
22. Special equipment or devices not usually used in your sport?	☐	☐	☐
23. Glasses, contacts, vision, or eye problems?	☐	☐	☐
24. Strain, sprain, fracture, joint pain, or swelling?	☐	☐	☐
25. Under the care of any other physician or specialist?	☐	☐	☐

Explain all **YES** responses here:

When was your last period (if applicable)? _____

Do you have concerns about periods? _____

_____ _____

Patient Name Today's Date

_____ _____

Signature of patient or parent/guardian if patient is under 18 Parent/Guardian Name & Relationship to Patient

By typing your name in the signature field, you confirm that the information provided above is accurate to the best of your knowledge and authorize disclosure of the requested information.

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