



Olson Pediatric Health History Questionnaire

We would be happy to fill out your form, please take a minute to answer the following questions.

Parent/Guardian:

Please review all questions and answer them to the best of your ability. Explain any YES answers on back.

YES	NO	Don't Know	
			1.) Has anyone in the participant's family died suddenly before the age of 50 years?
			2.) Has the participant ever passed out during exercise or stopped exercising because of dizziness or chest pain?
			3.) Does the participant have asthma (wheezing), hay fever, other allergies, or carry an EPI pen?
			4.) Is the participant allergic to any medications or bee stings?
			5.) Has the participant ever broken a bone, had to wear a cast, or had an injury to any joint?
			6.) Has the participant ever had a head injury or concussion?
			7.) Has the participant ever had a hit or blow to the head that caused confusion, memory problems, or prolonged headache?
			8.) Has the participant ever suffered a heat-related illness (heat stroke)?
			9.) Does the participant have a chronic illness or see a physician regularly for any particular problem?
			10.) Does the participant take any prescribed medicine, herbs or nutritional supplements?
			11.) Does the participant have only one of any paired organ (eyes, kidneys, testicles, ovaries, etc.)?
			12.) Has the participant ever had any prior limitation from sports participation?
			13.) Has the participant had any episodes of shortness of breath, palpitations, history of rheumatic fever or tiring easily?
			14.) Has the participant ever been diagnosed with a heart murmur or heart condition or hypertension?
			15.) Is there a history of young people in the participant's family who have had congenital or other heart disease: cardiomyopathy, abnormal heart rhythms, long QT or Marfan's syndrome? (you may write "I don't understand these terms" and initial this term, if appropriate.)
			16.) Has the participant ever been hospitalized overnight or had surgery?
			17.) Does the participant lose weight regularly to meet the requirements for this activity or sport?
			18.) Does the participant have anything he or she wants to discuss with the physician?
			19.) Does the participant cough, wheeze, or have trouble breathing during or after activity?
			20.) Are you (the participant) happy with your weight?
			21.) FEMALES ONLY: a. When was your first menstrual period? _____ b. When was your most recent menstrual period? _____ c. What was the longest time between menstrual periods in the last year? _____

Parent/Guardian/Participant's (if 18+) Statement:

I have reviewed and answered the questions above to the best of my ability. I and my child understand and accept that there are risks of serious injury and death in any sport or activity, including the one(s) in which my child has chosen to participate. I hereby give permission for the participant to participate in sports/activities.

Signed: _____ Print Name: _____

Relation to participant: _____ Today's Date: _____