POMONA UNIFIED SCHOOL DISTRICT
HEALTH SERVICES & PROGRAMS
HEART HEALTH HISTORY

Student:______________________________ D.O.B.:____________ Date:________Grade:___________

1. Name of heart problem (diagnosis): ____

2. When did your child's heart problem begin? Age______

3. Is this problem being followed by a doctor? Yes______ No______

4. Name of doctor or clinic: ____
   Address ____ City______________________
   Phone Number __________________________________

5. Date last seen for this condition: ____

6. Is your child taking any medication? Yes______ No______

7. Name of Medication: ____
   Dosage: ____
   Taken how often: ____

8. Symptoms to watch for: ____
   ____

9. Frequency of symptoms: ____
   ____

10. Date most recent symptoms occurred: ____

11. What do you do when symptoms occur? ____
    ____

12. Has your child ever been hospitalized for this condition? Yes________ No________
    If yes, please give dates and explain: ____
    ____

13. Has your child had any special test, or will he/she be having any procedure or surgery for this condition? Yes________ No________
    If yes, please explain: ____
    ____

14. Is your child on a special diet? Yes________ No________
    If yes, please explain: ____
    ____

15. Are there any limitations on physical activity? Yes________ No________
    If yes, please explain: ____
    ____

____ ________________________
Parent/Guardian Signature Date

PLEASE RETURN THIS FORM TO THE SCHOOL HEALTH OFFICE

Revised 07/13