PRE-PARTICIPATION MEDICAL HISTORY

PARTICIPATION WILL NOT BE ALLOWED UNTIL THIS IS COMPLETED

LAST NAME:	FIRST NAME:	MIDDLE INITIAL(S):

BIRTHDATE:	AGE:	SPORT(S):	ANTICIPATED COLLEGE GRADUATION YEAR:

ATTENTION: ADHD MEDICATIONS REQUIRE ADDITIONAL DOCUMENTATION PER NCAA REGULATIONS. PLEASE HAVE PRESCRIBING PHYSICIAN COMPLETE THE FOLLOWING DOCUMENT AND SUBMIT OUTLINED SUPPLEMENTAL DOCUMENTATION: NCAA ADHD REPORTING FORM

NAME OF MEDICATION:	REASON FOR USE:	DOSAGE AND FREQUENCY:
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ATTENTION: STUDENT-ATHLETES ARE REQUIRED TO PROVIDE THE ATHLETIC TRAINING STAFF WITH AN UNEXPIRED EPI-PEN, INHALER, DIABETIC MEDICATION AND/ OR ANY OTHER LIFE SAVING MEDICATIONS.

CHECK IF YOU USE THE FOLLOWING: ☐ EPI-PEN ☐ INHALER ☐ DIABETIC MEDICATION ☐ LIFE SAVING MEDICATION

DO YOU HAVE ANY ALLERGIES. IF YES, PLEASE SPECIFIC ALLERGY BELOW:

☐ **MEDICINES:** ☐ **FOOD:** ☐ **STINGING INSECTS:** ☐ **POLLEN** ☐ **OTHER:**

MEDICAL QUESTIONS

☐	**YES**	☐	**NO**	1. Has a doctor ever denied or restricted your participation in sports?
☐	**YES**	☐	**NO**	2. Do you have any ongoing medical conditions? If so, please identify ☐ Anemia ☐ Diabetes ☐ Infections ☐ Other:
☐	**YES**	☐	**NO**	3. Have you ever spent the night in the hospital?
☐	**YES**	☐	**NO**	4. Have you ever had surgery?
☐	**YES**	☐	**NO**	5. Have you ever been under the care of a psychologist, psychiatrist, or counselor?
☐	**YES**	☐	**NO**	6. Have you ever been diagnosed with anxiety, depression, or another mental health condition?
☐	**YES**	☐	**NO**	7. Do you cough, wheeze, or have difficulty breathing during or after exercise?
☐	**YES**	☐	**NO**	8. Have you ever used an inhaler or taken asthma medicine?
☐	**YES**	☐	**NO**	9. Is there anyone in your family who has asthma?
☐	**YES**	☐	**NO**	10. Were you born without or are you missing a kidney, eye, testicle, spleen, or any other organ?
☐	**YES**	☐	**NO**	11. Do you have groin pain or painful bulge or hernia in the groin area?
☐	**YES**	☐	**NO**	12. Have you had infectious mononucleosis within the last month?
☐	**YES**	☐	**NO**	13. Do you have any rashes, pressure sores, or other skin problems?
☐	**YES**	☐	**NO**	14. Have you had a herpes or MRSA skin infection?
☐	**YES**	☐	**NO**	15. Have you ever had a head injury or concussion?
☐	**YES**	☐	**NO**	16. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?
☐	**YES**	☐	**NO**	17. Do you have a history of seizure disorder?
☐	**YES**	☐	**NO**	18. Do you have headaches with exercise?
☐	**YES**	☐	**NO**	19. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?
☐	**YES**	☐	**NO**	20. Have you ever been unable to move your arms or legs after being hit or falling?
☐	**YES**	☐	**NO**	21. Have you ever become ill while exercising in the heat?
☐	**YES**	☐	**NO**	22. Do you get frequent muscle cramps when exercising?
☐	**YES**	☐	**NO**	23. Have you had any problems with your eyes or vision?
☐	**YES**	☐	**NO**	24. Have you had any eye injuries?
☐	**YES**	☐	**NO**	25. Do you wear glasses or contact lenses?
☐	**YES**	☐	**NO**	26. Do you wear protective eyewear?
☐	**YES**	☐	**NO**	27. Do you worry about your weight?
☐	**YES**	☐	**NO**	28. Are you trying to or has anyone recommended that you gain or lose weight?
☐	**YES**	☐	**NO**	29. Are you on a special diet or do you avoid certain types of foods?
☐	**YES**	☐	**NO**	30. Have you ever had an eating disorder?
☐	**YES**	☐	**NO**	31. Do you have any concerns that you would like to discuss with a doctor?
☐	**YES**	☐	**NO**	32. FEMALES ONLY: Have you ever had a menstrual period?
☐	**YES**	☐	**NO**	33. FEMALES ONLY: How old were you when you had your first menstrual period?
☐	**YES**	☐	**NO**	34. FEMALES ONLY: How many periods have you had in the last 12 months
☐	**YES**	☐	**NO**	35. Do you regularly use a brace, assistive device, or prosthetic?
☐	**YES**	☐	**NO**	36. Do you use any special brace or assistive device for sports?
☐	**YES**	☐	**NO**	37. Do you have rashes, pressure sores, or any other skin problems?
☐	**YES**	☐	**NO**	38. Do you have any hearing loss? Do you use a hearing aid?
☐	**YES**	☐	**NO**	39. Do you have a visual impairment?

☐	YES	☐	NO	40. Do you use any special devices for a bowel or bladder function?
☐	YES	☐	NO	41. Do you have any burning or discomfort with urination?
☐	YES	☐	NO	42. Have you had autonomic dysreflexia?
☐	YES	☐	NO	43. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?
☐	YES	☐	NO	44. Do you have muscle spasticity?
☐	YES	☐	NO	45. Do you have frequent seizures or seizure like activity that cannot be controlled by medication?
				HEART HEALTH QUESTON ABOUT YOU
☐	YES	☐	NO	46. Have you ever passed out or nearly passed out DURING or AFTER exercise?
☐	YES	☐	NO	47. Have you ever had discomfort, pain, tightness, or pressure in your chest DURING exercise?
☐	YES	☐	NO	48. Does your heart ever race or skip beats (irregular beats) DURING exercise?
☐	YES	☐	NO	49. Do you ever get light-headed, feel more short of breath, or tired than expected DURING exercise?
☐	YES	☐	NO	50. Has a doctor ever ordered a test for your heart?
☐	YES	☐	NO	51. Has a doctor ever told you that you have any heart problems such as heart murmur, high blood pressure, etc.?
☐	YES	☐	NO	52. Have you ever had a seizure?
☐	YES	☐	NO	53. Have you ever passed out or nearly passed out DURING or AFTER exercise?
				HEART HEALTH QUESTIONS ABOUT YOUR FAMILY
☐	YES	☐	NO	54. Has any family member or relative died of heart problems or had unexpected or unexplained sudden death before the age of 50?
☐	YES	☐	NO	55. Does anyone in your family have hypertrophic cardiomyopathy, Marfan Syndrome, long QT syndrome or other ion channelopathies, or clinically important arrhythmias?
☐	YES	☐	NO	56. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?
☐	YES	☐	NO	57. Does any family member or relative under the age of 50 have disability from heart disease?
				BONE AND JOINT QUESTIONS
☐	YES	☐	NO	58. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss practice or a game?
☐	YES	☐	NO	59. Have you ever had any broken or fractured bones or dislocated joints?
☐	YES	☐	NO	60. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?
☐	YES	☐	NO	61. Have you ever had a stress fracture?
☐	YES	☐	NO	62. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability (Down syndrome or dwarfism)?
☐	YES	☐	NO	63. Do you regularly use a brace, orthotics, or other assistive devices?
☐	YES	☐	NO	64. Do you have a bone, muscle, or joint injury that bothers you?
☐	YES	☐	NO	65. Do any of your joints become painful, swollen, feel warm, or look red?
☐	YES	☐	NO	66. Do you have any history of juvenile arthritis or connective tissue disease?

PLEASE STATE THE QUESTION NUMBER (1-66) FOLLOWED BY YOUR EXPLANATION FOR A "YES" ANSWER

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOUR CURRENT OR PAST MEDICAL HISTORY

☐	Atlantoaxial instability	☐	Difficulty controlling bowel	☐	Weakness in legs or feet
☐	X-ray evaluation for atlantoaxial instability	☐	Difficulty controlling bladder	☐	Recent change in coordination
☐	Dislocated joints	☐	Numbness or tingling in arms or hands	☐	Recent change in ability to walk
☐	Easy bleeding	☐	Numbness or tingling in legs or feet	☐	Spina bifida
☐	Enlarged spleen	☐	Weakness in arms or hands	☐	Latex allergy
☐	Hepatitis	☐	Weakness in legs or feet	☐	Osteopenia or osteoporosis

PLEASE EXPLAIN ALL THE BOXES YOU CHECKED STATING APPLY TO YOUR CURRENT OR PAST MEDICAL HISTORY

I hereby state to the best of my knowledge the answers provided are correct. I have not withheld any health information important to my safety and the safety of others. I have discussed my past medical and family history with my parents or guardians to ensure accuracy.

STUDENT-ATHLETE SIGNATURE:	PARENT/ GUARDIAN SIGNATURE IF STUDENT-ATHLETE IS UNDER 18:	DATE: