

Pre-Participation Questionnaire

Name: _____ Date: ____/____/____
Last First Middle

SSN _____ - _____ - _____ DOB ____/____/____ Sport _____

RHC Campus ID _____ - _____ - _____ Year: Freshman Sophomore

Address: _____ Home Phone _____ - _____ - _____
Street Apt

_____ Cell Phone _____ - _____ - _____
City State Zip

Family History:

Has anyone in your family had any of the following: **Please circle**

Heart Disease	Yes	No	Diabetes	Yes	No
High Blood Pressure	Yes	No	Cancer	Yes	No
Stroke	Yes	No	Tuberculosis	Yes	No
Sudden Death	Yes	No	Asthma	Yes	No
Epilepsy	Yes	No	Sickle Cell	Yes	No
Migraines	Yes	No	Eating Disorder	Yes	No

If yes, please explain: _____

Personal History:

Do you have or have you EVER had any of the following medical conditions? **Please circle**

High Blood Pressure	Yes	No	Hepatitis	Yes	No	Heat Stroke	Yes	No
Pericarditis	Yes	No	Blood Clots	Yes	No	Heat Exhaustion	Yes	No
Sickle Cell/Carrier	Yes	No	Cancer	Yes	No	Ear Infection	Yes	No
Anemia	Yes	No	Tumor/growth/cyst	Yes	No	Urinary Infection	Yes	No
Diabetes	Yes	No	Bronchitis	Yes	No	Hernia	Yes	No
Chicken Pox	Yes	No	Pneumonia	Yes	No	Mononucleosis	Yes	No
Measles	Yes	No	Asthma	Yes	No	Epilepsy	Yes	No
Mumps	Yes	No	Meningitis	Yes	No	Disordered Eating	Yes	No
Rubella	Yes	No	Migraines	Yes	No	Sexually Transmitted Infection	Yes	No

If yes, please explain: _____

Allergies:

Insect Bites/Stings	Yes	No	Penicillin	Yes	No
Grass/Pollen	Yes	No	Aspirin	Yes	No
Nuts	Yes	No	Anti-inflammatories	Yes	No
Melons	Yes	No	Anti-biotics	Yes	No
Other Foods	Yes	No	Other Medications	Yes	No
Have you ever developed a rash or hives during or after exercise			Yes	No	

If yes, please explain: _____

Mental Health History:

Do you have or have you EVER had any of the following medical conditions? **Please circle**

Attention Deficient Disorder	Yes	No	Panic Attacks	Yes	No
Depression / Unipolar	Yes	No	Phobias	Yes	No
Bipolar / Manic Depression	Yes	No	Personality Disorder	Yes	No
Anxiety Disorder	Yes	No	Paranoia	Yes	No
Obsessive Compulsive Disorder	Yes	No	Post Traumatic Stress Disorder	Yes	No
Eating Disorder	Yes	No			

If yes, please explain: _____

Check the appropriate space according to YOUR use of the following items:

	NEVER	RARELY	OCCASIONALLY	FREQUENTLY
Inhaler				
Vitamins				
Diet Pills				
Sleeping Pills				
Laxatives/Diuretics				
Alcoholic Beverages				
Antihistamines				
Allergy Medicine				
Anti-Inflammatories				
Aspirin				
Ibuprofen				
Caffeine				
Coffee/Energy Drinks				
Tobacco				
Protein Supplements				
Amino Acids				
Creatine				

Medical Care:

Have you been hospitalized in the past 12 months? Yes No _____
 Have you had surgery in the past 12 months? Yes No _____
 Are you currently under a doctor's care? Yes No _____
 Are you currently taking any medications? Yes No _____

Neurological:

Have you ever had a head injury/concussion? Yes No _____
 Have you ever been "knocked out"/unconscious? Yes No _____
 Have you ever had a seizure? Yes No _____
 Do you have recurring headaches? Yes No _____

General:

Do you have a history of asthma? Yes No _____
 Are you missing a kidney/lung/testicle? Yes No _____
 Do you have any problems with your vision?
 Glasses/contacts? _____ Yes No _____
 Have you had other medical problems?
 (Mononucleosis/anemia/diabetes) Yes No _____
 Do you currently have any skin problems?
 (Itching, rash, blisters, warts, etc.) Yes No _____

Cardiovascular:

Have you ever passed out during/after exercise? Y N
 Have you had chest pain during/after exercise? Y N
 Do you have high blood pressure? Y N
 Have you been told you have a heart murmur? Y N
 Have you ever had a racing heart or
 a skipped heart beat? Y N
 Has anyone in your family died of heart
 problems before the age of 50? Y N
 Have you ever had an EKG or echocardiogram? Y N

FEMALE Questionnaire:

Have you ever failed to menstruate for more than
 3 consecutive months? Y N
 Do you have irregular cycles (less than 21 days or
 greater than 35 days apart)? Y N
 Do you have abnormal flow (< 2 or > 7 days)? Y N
 Are you currently on birth control? Y N
 type/name: _____
 Do you take prescription or non-prescription
 medication for menstrual pain? Y N
 type/name: _____
 Have you had any pregnancies or births? Y N

I/We hereby state that, to the best of my/our knowledge, the answers to the above questions are correct.

 Student-athlete Signature

 Today's Date

 Parent/Guardian Signature if student-athlete is under 18

 Today's Date