Roberts Wesleyan College Sports Medicine
RETURNING ATHLETE Pre-Participation Health History

RETURNING ATHLETES: You are required to complete this annual health history update prior to clearance for continued participation in Roberts Wesleyan College athletics. This form must be completed **within six (6) months** before your first practice (traditional/non-traditional season). The Roberts Wesleyan College sports medicine staff will review this form, and will notify you if an examination or further tests are necessary.

Date_________________

Name____ Sex_______ Date of Birth_____________

Sport(s)________________ Graduation Year:__________ Email address_________________________

__________________________, ________________________, _____, ___________, ________________
Local Street Address City State ZIP Cell phone

Emergency Contact: __________________________, ________________, __________________________
Name Relationship Phone

Insurance Carrier:_________________________Policy ID#:____________________________________

Please answer the questions below regarding your health and athletic activities during the **PRECEDING 12 MONTHS. PLEASE EXPLAIN ALL "YES" ANSWERS IN THE AREA PROVIDED.** Any explanation that is omitted or unclear may delay clearance to participate. Please be as complete and accurate as possible.

MEDICAL ISSUES (Last 12 Months Only)

*Have you had a medical illness (particularly a severe viral or flu-like illness) or injury since your last checkup or sports physical? YES NO

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* Have you had infectious mononucleosis ("mono")? YES NO

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* Do you have any ongoing/chronic medical illnesses (diabetes, heart condition, etc.)? YES NO

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* Do you have asthma? YES NO

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* Do you have trouble breathing, cough, or wheeze during or after exercise? YES NO

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* Have you been hospitalized overnight? If so, please describe. YES NO

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* Have you seen a doctor because of an injury? YES NO

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* Have you had surgery? If so, please describe. YES NO

MEDICATIONS/SUPPLEMENTS (Last 12 Months Only)

*Are you regularly taking any medications (prescription or non-prescription) or using an inhaler? **PLEASE INCLUDE BIRTH CONTROL, ADDERALL/RITALIN** YES NO

* Have you been diagnosed with attention deficit disorder (ADD)? **NOTE: THE NCAA REQUIRES DOCUMENTATION OF FORMAL ADD TESTING** YES NO

* Are you presently taking vitamins, supplements to gain or lose weight, or supplements to aid performance? **ALLSUPPLEMENT USE MUST BE REPORTED!** YES NO

ALLERGIES (Last 12 Months Only)

* Do you have any allergies to medications, pollens, foods, or stinging insects? YES NO

* Have you developed a rash or hives during or after exercise? YES NO

HEART ISSUES (Last 12 Months Only)

* Have you had chest pain during or after exercise? If so, please describe. YES NO

* Have you been told that you have a heart murmur? YES NO

* Have you “passed out” during or after exercise? YES NO

* Have you felt dizzy during or after practice or competition? YES NO

* Do you tire more quickly with exertion than your teammates? YES NO

* Have you been diagnosed with high blood pressure or high cholesterol? YES NO

*Have you had an electrocardiogram (EKG), echocardiogram (sound wave test of the heart), or been evaluated by a heart specialist? YES NO

* Have you had severe or repeated racing of your heart or skipped heartbeats? YES NO

* Has anyone in your family died of heart problems or of sudden death before age 50? YES NO

* Has a physician denied or restricted your athletic participation for any reason? YES NO

NEUROLOGIC ISSUES (Last 12 Months Only)

* Have you had a head injury or concussion? If so, please describe. YES NO

* Have you been "knocked out," lost consciousness, or lost memory? YES NO

* Have you had a seizure? YES NO

* Do you suffer from frequent or severe headaches, particularly with exercise? YES NO

* Have you had a "stinger," "burner," or pinched nerve? YES NO

* Have you experienced numbness or tingling in your arms, hands, legs, or feet after being hit or falling? YES NO

ORTHOPAEDIC ISSUES (Last 12 Months Only)

*Have you had broken bones, dislocations, sprains or tendonitis that caused you to miss a practice or game?
YES NO

* Have you had a stress fracture? YES NO

* Do you use any special equipment (braces, neck rolls, eye guards, orthotics, etc.)? YES NO

NUTRITION (Last 12 Months Only)

*Do you have concerns about your EATING HABITS or have you been diagnosed with an EATING DISORDER or IRON DEFICIENCY/ANEMIA? YES NO

* Do you want to weigh more or less than you do? YES NO

* Do you lose weight regularly to meet the weight requirements/demands of your sport? YES NO

* Do you often skip meals or strictly limit/control what you eat? YES NO
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MISCELLANEOUS CONCERNS (Last 12 Months Only)

* Have you or a family member been diagnosed with SICKLE CELL DISEASE/TRAIT? YES NO
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* When exercising in the heat, do you have severe muscle cramps or become ill? YES NO
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* Have you been diagnosed with depression, anxiety, or panic attacks? YES NO
____

* Have you had any skin problems (acne, warts, herpes, etc)? YES NO
____

*Have you had any trouble with your eyes or vision?
Do you wear contact lenses/glasses? YES NO
____

FOR WOMEN ONLY:

At what age was your first menstrual period?___________________________
When was your last menstrual period? ________________________________
What was the longest time between periods last year?___________________
How many menstrual periods did you have in the last 12 months? _________
Are you now or have you previously taken birth control pills? ____________

I hereby state, to the best of my knowledge, that the answers to the above medical questions are correct and accurate. I grant permission to the Roberts Wesleyan College Sports Medicine staff to contact my family physician to discuss my past medical conditions and care if necessary.

Signature of athlete____ Date __________

Signature of Parent/Guardian (if athlete less than 18) __________________________ Date __________

Athlete is: Cleared   Needs MD's clearance   Needs full physical

Sports Medicine review [athletic trainer] by: __________________________________ Date: ___________