ROBERTS WESLEYAN UNIVERSITY

HEALTH HISTORY / SPORTS PRE-PARTICIPATION

**To be completed by ALL students*

Section 1: To be Completed by Student

Name: _____ Gender: _____ Birthdate: ____/____/____

Cell Phone: _____ Home Phone: _____ Email: _____

Circle: FR SO JR SR Sport(s): _____

MEDICAL

1.	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
2.	Have you had infectious mononucleosis ("mono")?	☐ YES ☐ NO
3.	Do you have any ongoing/chronic medical illnesses (diabetes, heart condition, etc.)?	☐ YES ☐ NO
4.	Do you have asthma?	☐ YES ☐ NO
5.	Do you have trouble breathing, cough, or wheeze during or after exercise?	☐ YES ☐ NO
6.	Have you been hospitalized overnight? *If so, please describe on back*	☐ YES ☐ NO
7.	Have you seen a doctor because of an injury	☐ YES ☐ NO
8.	Have you had surgery? *If so, please describe on back*	☐ YES ☐ NO

MEDICATIONS/SUPPLEMENTS: (Last 12 Months Only)

9.	Are you regularly taking any medications (prescription or non-prescription) or using an inhaler? PLEASE INCLUDE BIRTH CONTROL, ADDERALL/RITALIN *If so, please describe on back*	☐ YES ☐ NO
10.	Have you been diagnosed with attention deficit disorder (ADD)? NOTE: THE NCAA REQUIRES DOCUMENTATION OF FORMALL ADD TESTING	☐ YES ☐ NO
11.	Are you presently taking vitamins, supplements to gain or lose weight, or supplements to aid performance? ALL SUPPLEMENT USE MUST BE REPORTED	☐ YES ☐ NO

ALLERGIES: (Last 12 Months Only)

12.	Do you have any allergies to medications, pollens, foods, or stinging insects?	☐ YES ☐ NO
13.	Have you developed a rash or hives during or after exercise?	☐ YES ☐ NO

HEART

14.	Have you had chest pain during or after exercise? *If so, please describe on back*	☐ YES ☐ NO
15.	Have you been told that you have a heart murmur?	☐ YES ☐ NO
16.	Have you "passed out" during or after exercise	☐ YES ☐ NO
17.	Have you felt dizzy during or after practice or competition?	☐ YES ☐ NO
18.	Do you tire more quickly with exertion than your teammates?	☐ YES ☐ NO
19.	Have you been diagnosed with high blood pressure or high cholesterol?	☐ YES ☐ NO
20.	Have you had an electrocardiogram (EKG), echocardiogram (sound wave test of the heart), or been evaluated by a heart specialist?	☐ YES ☐ NO
21.	Have you had severe or repeated racing of your heart or skipped heartbeats?	☐ YES ☐ NO
22.	Has anyone in your family died of heart problems or of sudden death before age 50?	☐ YES ☐ NO
23.	Has a physician denied or restricted your athletic participation for any reason? *If so, please describe*	☐ YES ☐ NO

NEUROLOGIC

24.	Have you had a head injury or concussion? *If so, please describe on back*	☐ YES ☐ NO
25.	Have you been "knocked out," lost consciousness, or lost memory?	☐ YES ☐ NO
26.	Have you had a seizure?	☐ YES ☐ NO
27.	Do you suffer from frequent or severe headaches, particularly with exercise?	☐ YES ☐ NO
28.	Have you had a "stinger," "burner," or pinched nerve?	☐ YES ☐ NO
29.	Have you experienced numbness or tingling in your arm, hands, legs, or feet after being hit or falling?	☐ YES ☐ NO

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ROBERTS WESLEYAN UNIVERSITY

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**To be completed by ALL students*

ORTHOPAEDIC

30. Have you had broken bones, dislocations, sprains or tendonitis that caused you to miss a practice or game?	☐ YES	☐ NO
31. Have you had a stress fracture?	☐ YES	☐ NO
32. Do you use any special equipment (braces, neck rolls, eye guards, orthotics, etc.)?	☐ YES	☐ NO

NUTRITION: (Last 12 Months Only)

33. Do you have concerns about your EATING HABITS or have you been diagnosed with an EATING DISORDER or IRON DEFICIENCY/ANEMIA?	☐ YES	☐ NO
34. Do you want to weigh more or less than you do?	☐ YES	☐ NO
35. Do you lose weight regularly to meet the weight requirements/demands of your sport?	☐ YES	☐ NO
36. Do you often skip meals or strictly limit/control what you eat?	☐ YES	☐ NO

MISCELLANEIOUS

37. Have you or a family member been diagnosed with SICKLE CELL DISEASE/TRAIT?	☐ YES	☐ NO
38. When exercising in the heat, do you have severe muscle cramps or become ill?	☐ YES	☐ NO
39. Have you been diagnosed with depression, anxiety, or panic attacks?	☐ YES	☐ NO
40. Have you had any skin problems (acne, warts, herpes, etc.)?	☐ YES	☐ NO
41. Have you had any trouble with your eyes or vision?	☐ YES	☐ NO
42. Do you wear contact lenses/glasses?	☐ YES	☐ NO

FOR WOMEN ONLY

1. At what age was your first menstrual period? _____
2. When was your last menstrual period? _____
3. What was the longest time between periods last year? _____
4. How many menstrual periods did you have in the last 12 months? _____
5. Have you previously or are you now on birth control medication? _____

List all medications and supplements:

_____

_____

_____

Explain any "YES" answer below:

_____

_____

_____

List any additional comments about your medical history:

_____

_____

To the best of my knowledge, I hereby state that my answers to the above questions are accurate.

_____ _____ / _____ / _____

Signature of student Date

_____ _____ / _____ / _____

Signature of parent/guardian if student is under 18 Date

Student athletes MUST complete Section 2 to meet NCAA requirements