WESTMINSTER
ATHLETIC TRAINING

Preparticipation Health History Form

*Note: If seeing a physician, fill this form out **first** and bring to appointment. Otherwise fill out and submit with other medical forms.*

Name _____ Date of Birth _____ Sport(s) _____

Medicines and Allergies: **For substances on the NCAA Banned Substance list, the athlete must provide documentation from the prescribing physician and the current prescription, or risk failing any potential drug test.*

Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking:

Do you have any allergies? Y N _____ Medicines _____Pollens _____Food _____ Stinging Insects _____ Other
Explain: _____

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	YES	NO
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify: ____Asthma ____Anemia ____ Diabetes ____Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT *YOU*	**YES**	**NO**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats)?		
8. Has a doctor ever told you have any heart problems? If so, check all that apply: __ High Blood Pressure __ Heart murmur __ High cholesterol __ Heart infection __ Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (Example: ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT *YOUR FAMILY*	**YES**	**NO**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 40 (including drowning, unexplained car accident, or SIDS)?		
14. Does anyone in your family have hypertrophic cardio-myopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**YES**	**NO**
17. Have you ever had an injury to bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability?		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	YES	NO
26. Have you been diagnosed with Sickle Cell Disease?		
27. Has anyone in your family been diagnosed with Sickle Cell Disease?		
28. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
29. Have you ever used an inhaler or taken asthma medication?		
28. Is there anyone in your family who has asthma?		
30. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
31. Have you had infectious mononucleosis (mono) within 30 days?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Have you had any medical changes in the past 12 months?		
52. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
53. Have you ever had a menstrual period?		
54. How old were you when you had your first menstrual period?		
55. How many periods have you had in the last 12 months?		

Explain "Yes" answers here (use another sheet if necessary):

_____

_____

_____

_____

_____

_____

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_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Student-Athlete _____ Date _____

Parent/Guardian _____ Medical Reviewer _____ Date _____

(If student-athlete is under 18, parent/guardian must sign)

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