UNIVERSITY OF SAN DIEGO TOREROS CAMPUS RECREATION

SPORT CLUB HEALTH HISTORY FORM

***Complete as fillable PDF or use blue or black ink. *ALL ATHLETES MUST COMPLETE THIS FORM EVERY ACTIVE YEAR.**
RETURNING PARTICIPANTS: PLEASE UPLOAD COMPLETED FORM TO DSE PROFILE

Physical Exam Date (new members only):_____ **Sport(s):**_____ **Email:**_____

Name:_____ **Date of Birth:**_____ **USD ID #:**_____

Mark an "X" in one of the boxes below. Explain any "Yes" answers in the "Explain" section in the bottom right text section.

	YES	NO
GENERAL HISTORY:		
1. Has a medical provider ever denied or restricted your participation in sports for any reason?	☐	☐
2. Do you have an ongoing medical condition (like diabetes or asthma)?	☐	☐
3. Are you currently taking any prescription or over-the-counter medication or supplements? List names and what you take it for in "Explain" section.	☐	☐
4. Are you using alcohol, tobacco, marijuana or illegal substances? (Disclosure on this form is not required. Discuss with your provider.)		
5. Do you have allergies to medicines, pollens, foods, or stinging insects? If so, What? _____	☐	☐
6. Do you require medication for anaphalaxis?	☐	☐
7. If so, are teammates/friends aware of what your allergy is, medication location and how to assist you?	☐	☐
HEART HEALTH:		
8. Have you ever passed out or nearly passed out DURING exercise?	☐	☐
9. Have you ever passed our or nearly passed out AFTER exercise?	☐	☐
10. Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
11. Does your heart race / skip beats during exercise?	☐	☐
12. Has a medical provider ever told you that you have (check all that apply): ☐ High BP/Cholesterol ☐ Heart Murmur ☐ Positive Sickle Cell ☐ Heart Infection	☐	☐
13. Has a medical provider ever ordered a test for your heart (e.g., ECG, echocardiogram)?	☐	☐
FAMILY HEART HISTORY:		
14. Has anyone in your family died for no apparent reason?	☐	☐
15. Does anyone in your family have a heart problem?	☐	☐
16. Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
17. Does anyone in your family have Marfan syndrome?	☐	☐
OTHER HEALTH HISTORY:		
18. Have you ever spent the night in a hospital?	☐	☐
19. Have you ever had surgery?	☐	☐
20. Have you ever had an injury, like a sprain, muscle, or ligament tear, or tendonitis, that caused you to miss a practice or game? ***If yes, check affected area in chart below.**	☐	☐
21. Have you had any broken or fractured bones or dislocated joints? ***If yes, check affected area in chart below.**	☐	☐
22. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? ***If yes, check affected area in chart below.**	☐	☐

HEAD	NECK	SHOULDER	UPPER ARM	ELBOW	FOREARM	HAND/ FINGERS	CHEST
☐	☐	☐	☐	☐	☐	☐	☐
UPPER BACK	**LOWER BACK**	**HIP**	**THIGH**	**KNEE**	**CALF/ SHIN**	**ANKLE**	**FOOT/ TOES**
☐	☐	☐	☐	☐	☐	☐	☐

	YES	NO
23. Have you ever had a stress fracture?	☐	☐
24. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐
25. Do you regularly use a brace or an assistive device?	☐	☐
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
27. Is there anyone in your family who has asthma?	☐	☐
28. Have you ever used an inhaler or taken asthma medicine?	☐	☐
29. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
30. Have you had infectious mononucleosis (mono) within the last month?	☐	☐
31. Do you have an rashes, pressure sores or other skin problems?	☐	☐
32. Have you had a MRSA infection?	☐	☐
33. Have you had a herpes skin infection?	☐	☐
34. Have you had a concussion? If so, how many?_____ When was the most recent? _____	☐	☐
35. Have you been hit in the head and been confused or lost your memory?	☐	☐
36. Have you ever had a seizure or stroke?	☐	☐
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. When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
41. Has a medical provider told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
42. Have you had any problems with your eyes or vision?	☐	☐
43. Do you wear glasses or contact lenses?	☐	☐
44. Do you wear protective eye wear, such as goggles or a face shield?	☐	☐
45. Are you dissatisfied with your weight?	☐	☐
46. Are you trying to gain or lose weight?	☐	☐
47. Has anyone recommend you change your weight or eating habits?	☐	☐
48. Do you limit or carefully control what you eat?	☐	☐
49. Do you have any concerns that you would like to discuss with a medical provider?	☐	☐
FEMALES ONLY:		
50. Have you had a menstrual period?	☐	☐
51. How old were you when you had your first menstrual period?_____		
52. How many periods have you had in the last 12 months? _____		

Explain ALL "Yes" (except #50) answers here:

I hereby state that, to the best of my knowledge, the answers to the above questions are complete and correct.
I understand that intentional misrepresentation of the above information may pose a risk to my health and safety and may result in my exclusion from participating in sports clubs.

Signature of Club Athlete:_____ **Parent/Guardian Signature: (If under 18 years of age) :**_____ **Date:**_____