UNIVERSITY OF DELAWARE
STUDENT LIFE

Student Health Services
631 S. College Avenue
Bob Carpenter Center
Newark, DE 19716
Phone: 302-831-2482
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☐ Right Handed

☐ Left Handed

Sports Medicine Clinic
Pre-Participation Questionnaire

The University of Delaware requires a medical examination by a Student Health Service physician prior to participation in the intercollegiate athletic program. Please complete the following:

NAME: _____ **AGE:**_____ **BIRTHDATE:**_____

SPORT:_____ **POSITION:**_____

	YES	NO	
1.	☐	☐	Has a doctor ever denied or restricted your participation in sports for any reason?
	☐	☐	Do you have an ongoing medical condition? (like diabetes or asthma)
	☐	☐	Have you ever been hospitalized overnight?
	☐	☐	Have you had any surgery or operations, even minor one? (tonsillectomy, appendectomy)
	☐	☐	Have you ever had an injury that caused limitation of activity or required medical attention?

Please explain "YES" answers here: _____

_____

_____

2.	☐	☐	Are you currently taking any prescription or non-prescription (over-the-counter) medicines or pills?
	☐	☐	Do you take any supplements or vitamins?
	☐	☐	Are you allergic to any medications, stinging insects, foods, plants or pollen?
	☐	☐	Have you ever had a rash or hives develop during or after exercise?
	☐	☐	Have you ever been treated for or diagnosed with ADD/ADHD?

Please explain "YES" answers here: _____

_____

_____

3.	☐	☐	Do you have any skin problems? (i.e itching, rashes, acne, herpes, eczema, warts, fungus or blisters)
	☐	☐	Have you ever been told you have asthma?
	☐	☐	Do you cough, wheeze, or have trouble breathing during or after exercise?
	☐	☐	Have you ever had discomfort, pain or pressure in your chest during exercise?
	☐	☐	Have you ever had infectious mononucleosis? (mono)

Please explain "YES" answers here: _____

_____

_____

4.	☐	☐	Have you ever passed out or nearly passed out during or after exercise?
	☐	☐	Have you ever had discomfort, pain, tightness or pressure in your chest during or after exercise?
	☐	☐	Do you feel tired or short of breath more quickly than your friends during exercise?
	☐	☐	Have you ever had the feeling of your heart racing or skipped beats during or after exercise?
	☐	☐	Have you ever been told you had high blood pressure or high cholesterol in your blood?
	☐	☐	Have you ever had an electrocardiogram (EKG) of your heart?
	☐	☐	Have you ever had an echocardiogram (ultrasound) of your heart?
	☐	☐	Have you ever been told you have a heart murmur?
	☐	☐	Have you ever had a heart infection or been diagnosed with Kawasaki disease?
	☐	☐	Do you have any family members or relatives (parents, siblings, children, grandparents, aunts, uncles, cousins) that have died before age 50 of a heart condition (i.e Marfan Syndrome, Long or Short QT Syndrome, Hypertrophic Cardiomyopathy, Brugada Syndrome, Arrhythmogenic Right Ventricular Cardiomyopathy or Catecholaminergic Polymorphic Ventricular Tachycardia)?
	☐	☐	Do you have any family members or relatives (parents, siblings, children, grandparents, aunts, uncles, cousins) that have died unexpectedly before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?
	☐	☐	When exercising in the heat, do you have severe muscle cramps or become ill?
	☐	☐	Has a doctor told you that you or someone in your family has sickle cell trait or disease?
	☐	☐	Are you missing or have any non-functioning paired organs? (i.e kidneys, testicles, eyes)

Please explain "YES" answers here: _____

_____

_____

	YES	NO	
5.	☐	☐	Have you ever had a head injury?
	☐	☐	Have you ever had a concussion or been knocked unconscious?
	☐	☐	Have you ever had any seizures or convulsions?
	☐	☐	Do you have recurrent or frequent headaches?
	☐	☐	Do you have headaches with exercise/weight lifting?
	☐	☐	Have you ever had numbness or tingling in your arms or legs after hitting another player?
	☐	☐	Have you ever been unable to move your arms or legs after being hit or falling?

Please explain "YES" answers here: _____

_____

_____

6.	☐	☐	Do you require any special equipment? (braces, neck rolls, dental, orthotics, hearing aids, athletic cups)
	☐	☐	Do you wear jewelry that you do not remove during competition?

Please explain "YES" answers here: _____

_____

_____

7.	☐	☐	Do you have any problems with your eyes or vision?
	☐	☐	Do you wear glasses, contact lens, or protective eyewear when you play?

Please explain "YES" answers here: _____

_____

_____

8.	☐	☐	Have you had a tetanus booster within the last 10 years? When?_____
9.	☐	☐	Can you swim?
10.	☐	☐	Have you ever sprained/strained, dislocated, fractured/broken or other injuries to other bones/joints?
	☐	☐	Do you get shoulder pain when you throw, serve or swim?
	☐	☐	Have you ever had a shoulder separation or shoulder subluxation/dislocation?
	☐	☐	Have you ever had an elbow or hand injury?
	☐	☐	Have you ever had upper back pain or lower back pain?
	☐	☐	Do you have any hernias, pelvic or groin pain?
	☐	☐	Have you ever had pain or swelling in or around your knee?
	☐	☐	Have you had any ankle sprains, swelling or weakness?
	☐	☐	Have you ever had shin splints or stress fractures?
	☐	☐	Do you have painful feet (callous/bunions) or flat feet?
	☐	☐	Do you wear a brace or tape for participation?
	☐	☐	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, circle below. **Head Neck Shoulder Upper Arm Elbow Forearm Hand/Fingers Chest Upper Back Lower Back Hip Thigh Knee Calf/Shin Ankle Foot/Toes**
11.	☐	☐	Are you aware of any reason why you should not participate in the UD athletic program at this time?

Please explain "YES" answers here: _____

_____

_____

_____

_____

_____

AGREEMENT TO PARTICIPATE IN INTERCOLLEGIATE ATHLETICS:

Because of the dangers of participating in the above sport, I recognize the importance of following all instructions by the University of Delaware Athletics personnel. I understand and accept that I have the responsibility to report any and all injuries and illnesses, including signs and symptoms of concussions, to the medical staff at the University of Delaware. I have been presented with educational materials on concussions and understand that the University of Delaware Intercollegiate Athletic Program has a strict concussion management plan in place. I agree that I have been given the opportunity to ask questions about the concussion management plan and all other University of Delaware Athletics medical policies. I also understand that I may be medically disqualified from athletic participation if I fail to report concussion symptoms to medical/ athletic training staff at time of injury.

Student's Signature:_____ Date:_____ Time:_____ SHS Initial:_____

THE UNDERSIGNED, HEREWITH:

A. Understands that he or she must refrain from practice or play while ill or injured, whether or not receiving medical treatment, and during medical treatment until he or she is discharged from treatment or is given permission by the clinical practitioner to restart participation despite continuing treatment.
B. Understands that having passed the physical examination does not necessarily mean that he or she is physically qualified to engage in athletics, but only that the evaluator did not find a medical reason to disqualify him or her at the time of said examination.
C. Certifies that the answers to the questions above are correct or true.

Student's Signature:_____ Date:_____ Time:_____ SHS Initial:_____

RELEASE OF INFORMATION:

I hereby authorize the Student Health Service to release to the coach and/or trainer any information on my athletic physical examination or recertification relevant or pertinent to my participation in sports. I also hereby authorize the Student Health Service/Sports Medicine Clinic to release to Athletic Department Administration any information acquired in the course of my treatment for injuries/illnesses during my participation in sports at the University of Delaware for the purpose of determining the extent of the institution's liability.

Student's Signature:_____ Date:_____ Time:_____ SHS Initial:_____

Parent/Guardian's Signature (if under 18 years old): _____

PARENT'S OR GUARDIAN'S PERMISSION TO TREAT AND RELEASE (ATHLETES UNDER 18 YEARS OLD):

I hereby give my consent for the above student to engage in approved athletic activities as a representative of her/his school. I also give permission for the team physician, athletic trainers, or other qualified personnel to administer first aid treatment to this student at an athletic event in case of injury.

Parent/Guardian Signature:_____ Date:_____ Time:_____ SHS Initial:_____

Additional Questions (All questions are strictly confidential and will not be shared with parents or coaches):

	YES	NO	
12.	☐	☐	Do you smoke cigarettes, use smokeless tobacco, or use tobacco in any form?
	☐	☐	Have you used marijuana, cocaine, or any "street" recreational drugs?
	☐	☐	Do you have any questions regarding drugs, tobacco, or alcohol?
	☐	☐	Is there anyone in your family who regularly uses alcohol, cocaine, marijuana, or other drugs or has undergone treatment for alcohol-or drug-related problems?

Please explain "YES" answers here: _____

_____

_____

For the following questions, circle your answer:

	0	1	2	3	4
How often do you have a drink containing alcohol?	Never	Monthly or less	2- 4 times/month	2-3 times/week	4 or more times/week
How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
How often do you have 5 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

13.	☐	☐	Do you feel stressed out, and if yes, do you feel you get the necessary support to deal with your stress?
	☐	☐	Do you have activities or hobbies that you like to participate in outside of school and athletics?
	☐	☐	Do you feel as though you still enjoy those activities or hobbies?
	☐	☐	Do you ever have feelings of sadness, helplessness, hopelessness or depression? If yes, in how many of the last fourteen (14) days?_____
	☐	☐	Do you ever have feelings of being nervous, anxious or on edge? If yes, in how many of the last fourteen (14) days?_____
	☐	☐	Do you ever have feelings of not being able to control or stop worrying? If yes, in how many of the last fourteen (14) days?_____
	☐	☐	Have you ever been diagnosed with a psychiatric, mood or personality disorder? If yes, which one(s)?
	☐	☐	Have you ever been treated for any psychiatric, mood or personality disorder? If yes, what treatment(s)?

Please explain "YES" answers here: _____

_____

_____

14.	☐	☐	Have you ever been sexually active?
	☐	☐	Are you presently sexually active?
	☐	☐	Do you have any body piercing or tattoos?

(FEMALES ONLY!)

15.	☐	☐	Have you ever had a menstrual period? Age of onset_____
	☐	☐	Do you have painful or heavy periods? When was your most recent menstrual period?_____ How many periods have you had in the last 12 months?_____
	☐	☐	Do you take any medications during your periods?
	☐	☐	Do you take birth control pills or any female hormone (estrogen, progesterone) If yes, what brand? _____
	☐	☐	Have you ever had any problems with your breasts?
	☐	☐	Have you ever had a stress fracture?
	☐	☐	Have you ever been told you have low bone density (osteopenia or osteoporosis)?
	☐	☐	Have you had a pelvic examination within the last year?
	☐	☐	Would you like an appointment with our university gynecology services?

Please explain "YES" answers here: _____

_____

_____

Nutrition Screen- Information to be provided to Sports Nutritionist

Name:_____

1. Are you currently taking any vitamins, minerals or supplements? **Y/N**

   Please list brand and amount _____

2. Do you take any iron, vitamin C or vitamin D supplements? **Y/N**

   Please list brand and amount _____

3. Are you satisfied with the appearance of your body? **Y/N**

4. Have you had any recent changes in your weight over the last 6 months? **Y/N**

   Please explain _____

5. Does your weight fluctuate daily? **Y/N**

   How many lbs. per day _____

6. Are you happy with your weight? **Y/N**

   What change in weight would you like to see? Gain? Lose? Increase LBM?

7. Are you trying to gain or lose weight? **Y/N**. Has anyone recommended you gain or lose? **Y/N**

   Please explain_____

8. Do you ever feel out of control with your eating habits or experience guilt after eating? **Y/N**

   Please explain _____

9. Are you or have you ever followed a special diet, such as paleo, low carb. or gluten- free? **Y/N**

   Please explain_____

10. Has your appetite increased or decreased recently? **Y/N**

11. Are there any foods you strongly dislike or avoid? **Y/N**

    Please List _____

12. Do you drink alcohol? **Y/N**

    a. How many Drinks per week? _____

    b. What type of alcohol do you consume? _____

13. How many hours of sleep do you get?

    1-3 4 5 6 7 8 9 10+

14. How many days per week do you eat breakfast? _____

15. Please check any nutrition related question, concern or other needs you may have and would like to be addressed by our sports dietitian.

- Weight gain ☐
- Weight loss ☐
- Improve body composition ☐
- Body image ☐
- Meal or snack timing around training or competition ☐
- Increase energy levels ☐
- Hydration ☐
- Eating healthier on campus ☐
- Questions about supplements ☐
- Grocery shopping assistance ☐
- Eating healthier while dining out ☐
- Other _____

16. Have you restricted your food intake due to concerns about your weight or body size? **Y/N**

17. Have you had a history of anorexia, bulimia (forced vomiting), or any other eating disorder? **Y/N**

18. Have you used binge eating, vomiting, diet pills, sitting in a sauna, laxative use, diuretics (water pills), or similar techniques as a means of weight control? **Y/N**

19. Have you ever had an eating disorder? **Y/N**

Females Only

1. How old were you when you had your first period? _____
2. When was your most recent period? _____
3. Have your periods always been regular (occurring every 21-28 days)? **Y/N**
4. Were there any months where your period was late (>7days) or absent? **Y/N**
5. How many periods have you had in the past 12 months? _____
6. Are you taking a hormonal birth control? **Y/N**
    a. What medication are you taking? _____
    b. Were your periods regular prior to starting birth control?
7. Have you ever had a stress fracture? **Y/N**

    Where and when did it occur? _____
8. Have you ever had a DEXA or bone scan? **Y/N**

    Please list results if known _____
9. Have you ever been diagnosed with osteoporosis, osteopenia, or low bone density? **Y/N**