PREPARTICIPATION CLUB SPORT CLEARANCE

INITIAL HISTORY (1st of 2 PAGES)

***You must bring a copy of your immunization record to the clearance exam.***

**SPORT:**

Explain “yes” answers below. Circle questions if you don’t know the answers.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Yes** | **No** |  | **Yes** | **No** |
| 1. Has a doctor ever denied or restricted your sports participation for any reason?
 |  |  | LUNG QUESTIONS19. Has a doctor ever told you that you have asthma or allergies? |  |  |
| 1. Do you have an ongoing medical condition (like diabetes or asthma)?
 |  |  |
| 1. Have you ever been hospitalized or had a serious illness?
 |  |  | 20. Do you cough, wheeze, or have difficulty breathing during or after exercise? |  |  |
| 1. Were you born without or are you missing a kidney, spleen, testicle, or any other organ?
 |  |  | 21. Have you ever used an inhaler or taken asthma medicines?  |  |  |
| 1. Are you currently taking any prescription or nonprescription (over-the-counter) medicines, including birth control pills?
 |  |  | SKIN QUESTIONS22. Have you had any rashes or other skin problems?  |  |  |
| 1. Do you take any vitamins or supplements?
 |  |  | 23. Have you had skin infections such as herpes, impetigo, or Staph (MRSA)?  |  |  |
| 1. Do you have allergies to medicines, pollens, foods or stinging insects?
 |  |  | NEUROLOGY QUESTIONS24. Have you ever had a head injury or concussion?  |  |  |
| HEART QUESTIONS1. Have you ever passed out or nearly passed out DURING exercise?
 |  |  | 25. Have you ever been hit in the head and been confused or lost your memory?  |  |  |
| 26. Have you ever had a seizure? |  |  |
| 1. Have you ever passed out or nearly passed out AFTER exercise?
 |  |  | 27. Do you have headaches with exercise? |  |  |
| 1. Have you ever had discomfort, pain, or pressure in your chest during exercise?
 |  |  | 28. Have you ever had numbness, tingling, or  weakness in your arms or legs after being hit or  falling? |  |  |
| 1. Does your heart race or skip beats during exercise?
 |  |  | 29. Have you ever been unable to move your arms  or legs after being hit or falling?  |  |  |
| 1. Has a doctor ever told you that you have (check all that apply):

 □ High blood pressure □ Heart murmur  □ High cholesterol □ Heart infection | xx | xx | 30. When exercising in the heat, have you ever  had severe muscle cramps or become ill? |  |  |
| 1. Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram)
 |  |  | VISION QUESTIONS31. Have you had any problems with your eyes or  vision? |  |  |
| FAMILY QUESTIONS1. Has any family member or relative died of heart problems or of sudden and/or unexplained death before age 50?
 |  |  | 32. Do you wear glasses or contact lenses? |  |  |
| 33. Do you have any concerns that you would like  to discuss with a doctor? |  |  |
| 1. Does anyone in your family have asthma?
 |  |  |
| 1. Does anyone in your family have a significant illness such as heart problems, diabetes, etc.?
 |  |  |
| 1. Does anyone in your family have Marfan’s Syndrome?
 |  |  |
| 1. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?
 |  |  |

**Explain “YES” answers here:**

PREPARTICIPATION CLUB SPORT CLEARANCE INITIAL HISTORY (2nd of 2 PAGES)

***You must bring a copy of your immunization record to the clearance exam.***

Explain “yes” answers below. Circle questions if you don’t know the answers.

|  |  |  |
| --- | --- | --- |
|  | **YES** |  **NO** |
| MENTAL HEALTH QUESTIONS34. Have you ever been severely depressed? |  |  |
| 35. Are you taking or have you ever taken medications for depression or other mental health problems? |  |  |
| 36. Have you ever received medical care or been hospitalized for mental health problems or an eating disorder? |  |  |
| 37. Have you ever been treated for Attention Deficit Hyperactivity Disorder (ADD or ADHD)? |  |  |
| SUBSTANCE USE QUESTIONS1. In an average week, how many alcoholic drinks will you have?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |  xxx | xxxx |
| 39. Have you ever passed out or had memory blanks as a result of drinking? |  |  |
| 40. Have you ever felt like you ought to cut down on your drinking? |  |  |
| 41. Have you ever or do you currently smoke marijuana? |  |  |
| 42. Have you ever used other recreational drugs besides marijuana? |  |  |
| WEIGHT QUESTIONS43. Are you trying to gain or lose weight? |  |  |
| 44. Has anyone recommended you change your weight or eating habits? |  |  |
| 45. Do you limit or carefully control what you eat? |  |  |
| **FEMALES ONLY**46. How old were you when you had your first menstrual period?\_\_\_\_\_\_\_\_\_ |  |  |
| 47. Have you ever missed a menstrual period? |  |  |
| 48. How many periods have you had in the last 12 months?\_\_\_\_\_\_\_\_\_\_\_\_\_  |  |  |

|  |  |  |
| --- | --- | --- |
| ORTHOPEDIC QUESTIONS49. Have you ever had a stress fracture? |  |  |
| 50. Have you been told that you have or have you had an X-ray for neck instability? |  |  |
| 51. Do you regularly use a brace or assistive device? |  |  |
| 52. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis that caused you to miss a practice or game?  |  |  |
| 53. Have you had any broken or fractured bones or dislocated joints?  |  |  |
| 54. Have you had a bone or joint injury that required X-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, cast or crutches? |  |  |

|  |
| --- |
| **CIRCLE any area below that is INJURED currently or has been in the past:** |
| Head | Neck | Upper Back | ShoulderR L | Upper ArmR L | ElbowR L | ForearmR L | Hand/FingersR L |
| Chest | Lower Back | HipR L | ThighR L | KneeR L | Calf/ShinR L | AnkleR L | Foot/ToesR L |

**Explain “YES” answers here:**

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRINT NAME