SAN DIEGO STATE SPORT CLUBS

SDSU Pre-Participation Health History Form

Name: _____ Sex:_____ Age: _____ DOB:_____

Club Team: _____ Cell Phone: _____ Email: _____

Local Address:_____

Red ID: _____

EXPLAIN ALL "Yes" answers in box at end of this section (Page 3).	**YES**	**NO**	**I DON'T KNOW**
1. Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐	☐
2. Do you have an ongoing medical condition (like diabetes or asthma)?	☐	☐	☐
List:			
3. Are you currently taking any prescription or Nonprescription (over-the-counter) medicine or pills?	☐	☐	☐
List:			
4. Do you have allergies to medicines, pollens, foods or stinging insects?	☐	☐	☐
5. Have you ever passed out or nearly passed out DURING exercise?	☐	☐	☐
6. Have you ever passed out or nearly passed out AFTER exercise?	☐	☐	☐
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐	☐
8. Does your heart race or skip beats during exercise?	☐	☐	☐
9. Has a doctor ever told you that you have (check all that apply)	☐	☐	☐
☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection			
10. Has a doctor ever ordered a test for your heart (ECG, echocardiogram, etc)?	☐	☐	☐
11. Has anyone in your family died for no apparent reason?	☐	☐	☐
12. Does anyone in your family have a heart problem?	☐	☐	☐
13. Has any family member or relative died of heart problems or sudden death before age 50?	☐	☐	☐
14. Does anyone in your family have Marfan syndrome?	☐	☐	☐
15. Have you ever spent the night in the hospital?	☐	☐	☐
16. Have you ever had surgery?	☐	☐	☐
If you answer YES to questions 17, 18 or 19, please complete the MUSCULOSKELETAL HISTORY SECTION			
17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis, that caused you to miss practice or game?	☐	☐	☐
18. Have you ever had any broken or fractured bones or dislocated joints?	☐	☐	☐
19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, cast, crutches?	☐	☐	☐

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EXPLAIN ALL "Yes" answers in box at end of this section (Page 3).	**YES**	**NO**	**I DON'T KNOW**
20. Have you ever had a stress fracture?	☐	☐	☐
21. Have you ever been told you have or have had an x-ray for atlantoaxial (neck) instability?	☐	☐	☐
22. Do you regularly use a brace or an assistive device?	☐	☐	☐
23. Has a doctor ever told you that you have asthma or have you ever been given an inhaler?	☐	☐	☐
24. Is there anyone in your family who has asthma?	☐	☐	☐
25. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐	☐
26. Do you currently use an inhaler or take Asthma medicine?	☐	☐	☐
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐	☐
28. Have you had infectious mononucleosis (mono) within the last month?	☐	☐	☐
29. Do you have any rashes, pressure sores or other skin problems?	☐	☐	☐
30. Have you ever had a herpes skin infection?	☐	☐	☐
31. Have you ever had a head injury or concussion?	☐	☐	☐
If so, when was your last one? _____			
How many have you had? _____			
Current problem?_____			
32. Have you been hit in the head and been confused or lost your memory?	☐	☐	☐
33. Have you ever had a seizure?	☐	☐	☐
34. Do you have headaches with exercise?	☐	☐	☐
35. Have you ever had numbness, tingling, or weakness in your arms or legs after a hit or fall?	☐	☐	☐
36. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐	☐
37. When exercising in the heat, do you have muscle cramps or become ill?	☐	☐	☐
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐	☐
39. Have you ever had any problems with eyes/vision?	☐	☐	☐
40. Do you wear glasses or contact lenses?	☐	☐	☐
41. Do you wear protective eyewear, such as goggles or a face shield	☐	☐	☐
42. Are you happy with your weight?	☐	☐	☐
43. Are you trying to gain or lose weight?	☐	☐	☐
44. Has anyone recommend you change your weight or eating habits?	☐	☐	☐
45. Do you limit or carefully control what you eat?	☐	☐	☐
46. Do you have any concerns that you would like to discuss with a doctor?	☐	☐	☐
FEMALES ONLY:			
47. Have you ever had a menstrual period?	☐	☐	☐
48. How old were you when you had your 1st period _____			
49. How many periods have you had in the last 12 months _____			

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EXPLAIN ALL "Yes" answers:

Please include the question number(s) with your answer(s).

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

Athlete Name: _____ Athlete Signature:_____ Date: _____

Parent Name: _____ Parent Signature:_____ Date:_____

(If athlete is under 18)

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Please check a response for each of the following: I…

	Always	Usually	Often	Sometimes	Rarely	Never	OFFICE USE ONLY Score
1. Am terrified about being overweight	☐	☐	☐	☐	☐	☐	____
2. Avoid eating when I am hungry	☐	☐	☐	☐	☐	☐	____
3. Find myself preoccupied with food	☐	☐	☐	☐	☐	☐	____
4. Have gone on eating binges where I feel that I may not be able to stop	☐	☐	☐	☐	☐	☐	____
5. Cut my food into small pieces	☐	☐	☐	☐	☐	☐	____
6. Aware of the calorie content of foods that I eat	☐	☐	☐	☐	☐	☐	____
7. Particularly avoid foods with high carbohydrate content (i.e. bread, rice, potatoes, etc.)	☐	☐	☐	☐	☐	☐	____
8. Feel that others would prefer if I ate more	☐	☐	☐	☐	☐	☐	____
9. Vomit after I have eaten	☐	☐	☐	☐	☐	☐	____
10. Feel extremely guilty after eating	☐	☐	☐	☐	☐	☐	____
11. Am preoccupied with a desire to be thinner	☐	☐	☐	☐	☐	☐	____
12. Think about burning calories when I exercise	☐	☐	☐	☐	☐	☐	____
13. Other people think that I am too thin	☐	☐	☐	☐	☐	☐	____
14. Am preoccupied with the thought of having fat on my body	☐	☐	☐	☐	☐	☐	____
15. Take longer than others to eat my meals	☐	☐	☐	☐	☐	☐	____
16. Avoid foods with sugar in them	☐	☐	☐	☐	☐	☐	____
17. Eat diet foods	☐	☐	☐	☐	☐	☐	____
18. Feel that food controls my life	☐	☐	☐	☐	☐	☐	____
19. Display self-control around food	☐	☐	☐	☐	☐	☐	____
20. Feel that others pressure me to eat	☐	☐	☐	☐	☐	☐	____
21. Give too much time and though to food	☐	☐	☐	☐	☐	☐	____
22. Feel uncomfortable after eating sweets	☐	☐	☐	☐	☐	☐	____
23. Engage in dieting behavior	☐	☐	☐	☐	☐	☐	____
24. Like my stomach to be empty	☐	☐	☐	☐	☐	☐	____
25. Enjoy trying new rich foods	☐	☐	☐	☐	☐	☐	____
26. Have the impulse to vomit after meals	☐	☐	☐	☐	☐	☐	____

	NO	YES	How many times in the last 6 months?
27. Have you gone on eating binges where you feel that you may no be able to stop? (Eating much more than most people would eat under the same circumstance?)	☐	☐	_____
28. Have you ever made yourself sick (vomited) to control your weight or shape?	☐	☐	_____
29. Have you ever used laxatives, diet pills or diuretics (water pills) to control your weight or shape?	☐	☐	_____
30. Have you ever been treated for an eating disorder?	☐	☐	_____
31. Have you ever been diagnosed as having an eating disorder (anorexia, bulimia, or both?)	☐	☐	_____

Please list your: Highest weight _____, Lowest weight _____, Goal weight _____

Athlete Name: _____ Athlete Signature:_____ Date: _____

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COVID-19 Questionnaire

1. Have you received the COVID-19 vaccine? ☐ Yes ☐ No

   If yes, please specify which vaccine received ☐ Moderna ☐ Pfizer ☐ Johnson & Johnson (J&J)

   Please note the dates of second dose (Moderna/Pfizer) or single dose (J&J) _____

2. Have you received a booster shot(s) for COVID-19? ☐ Yes ☐ No

   If yes, please note the date(s) received _____

3. Have you tested positive for COVID within the last 90 days? ☐ Yes ☐ No

   If yes, please provide the positive test date _____

   Medical clearance from an MD or DO is required for anyone who has had a positive test within 45 days of their return to activity.

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Musculoskeletal History Section:

Please list fractures, sprains, strains, dislocations, cartilage injuries, etc. If you need more room use lines at end of the section.

	Type of Injury	Date	Treatment	Fully Resolved?
Ankle	R ☐			Yes ☐ NO ☐
	L ☐			Yes ☐ NO ☐
Foot	R ☐			Yes ☐ NO ☐
	L ☐			Yes ☐ NO ☐
Knee	R ☐			Yes ☐ NO ☐
	L ☐			Yes ☐ NO ☐
Hip/Leg	R ☐			Yes ☐ NO ☐
	L ☐			Yes ☐ NO ☐
Hand	R ☐			Yes ☐ NO ☐
	L ☐			Yes ☐ NO ☐
Wrist	R ☐			Yes ☐ NO ☐
	L ☐			Yes ☐ NO ☐
Elbow	R ☐			Yes ☐ NO ☐
	L ☐			Yes ☐ NO ☐
Shoulder	R ☐			Yes ☐ NO ☐
	L ☐			Yes ☐ NO ☐
Chest/Ribs				Yes ☐ NO ☐
Neck				Yes ☐ NO ☐
Back				Yes ☐ NO ☐
Head/Face				Yes ☐ NO ☐

Any other significant injury to your body? (please explain)

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General Questions:

Have you ever been hospitalized overnight? (please explain)

Have you ever had any surgeries? (please explain)

Do you have ANY medical problems you have not yet listed that require regular treatment or medical attention?

Have you seen a doctor in the last year?

Are you currently experiencing any symptoms or in any way feel not well?

I hereby certify that I have completed this questionnaire completely and correctly to the best of my ability and knowledge. I certify that there are no illnesses or injuries, current or previous, that I have not incurred, other than those I have listed on the preceding pages.

Athlete Name: _____ Athlete Signature:_____ Date: _____

Parent Name: _____ Parent Signature:_____ Date:_____
(If athlete is under 18)

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