SAN DIEGO STATE SPORT CLUBS

MEDICAL QUESTIONNAIRE FOR RETURNING ATHLETES

Name:_____ Red ID #_____ Cell Phone: _____

Date:_____ Year at SDSU: ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th ☐ 6th Sport: _____

Since your last physical or returning medical 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.

4. Have you experienced 1) chest pain/discomfort with exertion 2) fainting/near fainting or 3) excessive, unexpected or unexplained shortness of breath or fatigue associated with exercise? ☐ Yes ☐ No If yes, please explain:

5. Have you been diagnosed with a heart condition, murmur, or increased systemic blood pressure? ☐ Yes ☐ No If yes, please explain:

6. Have you become aware of any premature deaths (sudden or otherwise), or significant disability from cardiovascular disease in close relative(s) younger than 50 yrs old or specific knowledge of the occurrence of certain conditions (e.g. hypertrophic cardiomyopathy, dilated cardiomyopathy, long QT syndrome, Marfan Syndrome, or clinically important arrhythmias)? ☐ Yes ☐ No If yes, please explain:

7. Have you had any surgery, developed a new drug allergy or new illness requiring the care of a physician since your last physical exam or questionnaire? ☐ Yes ☐ No If yes, please explain:

8. Have you been injured OR has any physician recommended you limit your sports participation since your season ended or during the summer, including Sickle Cell Trait diagnosis? ☐ Yes ☐ No If yes, please explain:

9. Please list any medications or nutritional supplements you are currently taking:

10. Do you feel you need to see a physician? ☐ Yes ☐ No If yes, please explain:

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11. Do you currently have any symptoms of injury or illness? ☐ Yes ☐ No If yes, please explain:

12. Do you take any medications for ADHD and/or anabolic steroids for any reason? ☐ Yes ☐ No If yes, please explain:

13. In the past year have you been diagnosed with an eating disorder or do you have any concerns regarding eating habits that you would like to discuss with aphysician? ☐ Yes ☐ No If yes, please explain:

Athlete Name:_____ Athlete Signature:_____ Date: _____

☐ Reviewed/No Action ☐ Action Required Initials/Date: _____/_____

Comments: