A.S. SDSU Sport Clubs
MEDICAL QUESTIONNAIRE FOR RETURNING SPORTS CLUB ATHLETES

Date: __________________________ Name: __________________________ Sport: __________________________

Red ID Number: __________________________ Phone Number: __________________________ E-Mail: __________________________

Year: __________ 2nd __________ 3rd __________ 4th __________ 5th __________ 6th __________ Other

Since Your Last Athletic Physical or Returning Medical Questionnaire:

1. 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: __________________________

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

3. Have you become aware of any premature deaths (sudden or otherwise), or significant disability from cardiovascular disease in close relative(s) younger than 50 years 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: __________________________

4. 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: __________________________

5. Have you been injured OR has any physician recommended you limit your sports participation since your season ended or during the summer?
   
   ________ Yes ________ No  If yes, please explain: __________________________

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

   ____________________________________________

7. Do you feel you need to see a physician?
   
   ________ Yes ________ No  If yes, please explain: __________________________

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

ATHLETE SIGNATURE: __________________________ DATE: __________________________

Office Use Only:
Reviewed By: __________________________ Action Required: __________________________ No Action Required: __________________________ Date: __________________________