Student #:

Pre-Participation Health Questionnaire

Western Mustangs

Today's Date: _____/_____/_____ Name: _____

Date of Birth: _____/____/_____ E-mail: _____

Sport _____ & Year ___ Academic Program _____ & Year ___ Sex: F M

Home Address: _____
Street City Province Postal Code

Family Doctor's Name: _____ City: _____

Your Home Phone: _____ Cell: _____

EMERGENCY CONACT: Name & Relationship (ie. Parent, Sibling):

_____

Contact Home Phone #: _____ Business #: _____ Cell#: _____

Family History:

	Has anyone in your family:		If yes who
	•died suddenly and unexpectedly(under 50 yrs old)?	Yes / No	
	•had significant cardiovascular disease under 50 years	Yes / No	
	• been treated for recurrent fainting?	Yes / No	
	• had heart surgery?	Yes / No	
	• been diagnosed with Marfans	Yes / No	
	• been diagnosed with irregular heart rhythm	Yes / No	
	• been diagnosed with cardiomyopathy	Yes / No	
	• been diagnosed with hypertrophic or dilated heart?	Yes / No	
	•had inherited heart rhythm problem (long QT syndrome, Brugada syndrome, etc.	Yes / No	
	• had connective tissue disorders?	Yes / No	
	•had Heart Disease or High Blood Pressure?	Yes / No	
	• Other: Cancer, Diabetes, Liver, Lung, Kidney	If yes please explain :	

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Personal Medical History: ***Have*** you had any of the following?

	Cardiorespiratory	
	Have you ever fainted or passed out when exercising?	Yes No
	Do you ever have chest tightness?	Yes No
	Does exercise ever cause chest tightness?	Yes No
	Have you ever had chest tightness, cough, wheezing which made it difficult for you to perform in sports?	Yes No
	Have you ever been treated or hospitalized for asthma?	Yes No
	Have you ever been told to give up sports because of health problems?	Yes No
	Have you ever been told you have high blood pressure?	Yes No
	Have you ever been told you have high cholesterol?	Yes No
	Do you have trouble breathing during or after activity	Yes No
	Do you cough during or after activity?	Yes No
	Have you ever been dizzy during or after exercise?	Yes No
	Have you ever had chest pain during or after exercise?	Yes No
	Do you have or have you ever had racing of your heart or skipped heartbeats?	Yes No
	Do you get tired more quickly than your friends do during exercise?	Yes No
	Have you ever been told you have a heart murmur?	Yes No
	Have you ever been told you have a heart arrhythmia?	Yes No
	Do you have any other history of heart problems?	Yes No
	Have you had a severe viral infection (for example myocarditis or mononucleosis) within the last month?	Yes No
	Have you ever been told you had rheumatic fever?	Yes No

Neurology and Concussion

	Have you ever had a seizure?	Yes No
	Have you ever been told that you have epilepsy?	Yes No
	Have you ever been knocked out or become unconscious?	Yes No
	Have you had frequent or severe headaches / migraines?	Yes No
	Have you had a stinger, burner or pinched nerve?	Yes No
	Have you had numbness or tingling in your arms, hands legs feet?	Yes No
	Do you have ADHD / ADD or other learning disability	Yes No
	Have you ever had a head injury or concussion (IF yes list in chart)	Yes No

	Year	Sport	Unconscious Y/N and/or amnesia	How Long	Seen By MD	Kept in Hospital	How long off sports	Off School	Still a problem Y / N	Any test-CT, MRI
1										
2										
3										
4										

Student #:

Please score yourself on the following symptoms, based on how YOU FEEL NOW.					
	None Moderate Severe		None Moderate Severe		0 1 2 3 4 5 6
Headache	0 1 2 3 4 5 6	Sensitivity to Light	0 1 2 3 4 5 6	Trouble Falling Asleep	0 1 2 3 4 5 6
"Pressure In Head"	0 1 2 3 4 5 6	Sensitivity to Noise	0 1 2 3 4 5 6	More Emotional	0 1 2 3 4 5 6
Neck Pain	0 1 2 3 4 5 6	Feeling slowed down	0 1 2 3 4 5 6	Irritability	0 1 2 3 4 5 6
Nausea or Vomiting	0 1 2 3 4 5 6	Feeling like "in a fog"	0 1 2 3 4 5 6	Sadness	0 1 2 3 4 5 6
Dizziness	0 1 2 3 4 5 6	Don't Feel Right	0 1 2 3 4 5 6	Nervous or Anxious	0 1 2 3 4 5 6
Blurred Vision	0 1 2 3 4 5 6	Difficulty concentrating	0 1 2 3 4 5 6		
Balance Problems	0 1 2 3 4 5 6	Difficulty remembering	0 1 2 3 4 5 6		
Confusion	0 1 2 3 4 5 6	Drowsiness	0 1 2 3 4 5 6		

	Do the symptoms get worse with physical activity	Yes	No
	Do the symptoms get worse with mental activity	Yes	No

Ear / Nose/ Throat

	Do you wear glasses?	Yes	No	During Sport	Yes	No
	Do you wear contacts?	Yes	No	During Sport	Yes	No
	Do you wear a mouth guard?	Yes	No	During Sport	Yes	No
	Do you wear dentures, false teeth or oral braces?	Yes	No	During Sport	Yes	No
	Do you use any other sensory (ie Hearing) aids?	Yes	No	Explain:		
	Do you have any malfunctioning or missing organs? (kidney-liver-spleen-bowel-testicles-etc)	Yes	No	Explain:		
	Do you have any malfunctioning or missing senses such as vision, hearing, taste or smell?	Yes	No	Explain:		

Gastrointestinal / GU / Endo

	Have you ever had any bowel issues?	Yes	No	
	Have you ever had any issue with kidney function?	Yes	No	
	Have you ever been treated for Diabetes ?	Yes	No	
	Have you ever had endocrine or thyroid issues?	Yes	No	

Dermatology

	Have you been treated for skin conditions? If yes please explain:	Yes	No	
	Have you ever been restricted from Sport due to a skin condition.	Yes	No	

Heat illness

	Have you ever had heat illness or heat exhaustion	Yes	No	Date :
	Have you ever seen a Physician for heat illness	Yes	No	
	Do you have problems with exercising in the heat ?	Yes	No	

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Immunizations: Provide year of last immunized if known.

Tetanus/Diphtheria	Yes _____	No	Don't know
Hepatitis A	Yes	No	Don't know
Hepatitis B	Yes	No	Don't know
Flu Shot / Other Immunization.	Yes	No	Don't know
HPV Vaccine	Yes	No	Don't know
Meningitis shot	Yes	No	Don't know
Chicken pox	Yes	No	Don't know
MMR	Yes	No	Don't know

Female Athlete Review:

	How old were you when you had your first menstrual period?	Age
	How many periods have you had in the past12 months	Number _____
	What was the longest time between periods in the past year?	Number of days _____
	How many days do your period last?	Number of days _____
	Are your periods – light , moderate , heavy	Circle: light moderate heavy
	Have you ever gone for more than 3 months without having a menstrual period?	Yes No
	Normal duration between periods?	_____Days
	When was your last menstrual period (LMP)?	____/____/_____
	Are you sexually active?	Yes No
	Do you have any concerns about sexually transmitted infections?	Yes No
	Do you take hormones (pill, patch, injection) for birth control?	Yes No If yes name: & reason if other than for birth control
	Have you ever had a pap test?	*Yes No* *If Yes, most recent:*
	Have you ever been treated for anemia?	Yes No

Musculoskeletal Injury History: ***Please list any injuries***

Past Injury	Year	L or R	Diagnosis if known	Seen by? MD? Therapist?	Treatment	Still a problem Yes / No
Hand						
Wrist						
Forearm						
Elbow						
Upper Arm						
Shoulder						

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Collarbone						
Neck						
Ribs / Chest						
Back Upper / Lower						
Hip						
Thigh						
Knee						
Ankle						
Foot						

Lifestyle and Health Issues:

	Have you had any recent weight changes?	Yes	No	If yes – amount?
	Satisfied with your CURRENT weight?	Yes	No	If no – goal weight?
	Are there certain foods you avoid?	Yes	No	If Yes – What?
	Do you have any dietary problems?	Yes	No	If Yes – Please list
	Ever tried to CONTROL your weight with? YES NO ( ) fasting ( ) vomiting ( ) laxatives ( ) diuretics ( ) diet pills ( ) exercise ( ) other:			
	Do you lose weight regularly to meet the requirements of your sport?			Yes No
	Do you have questions about healthy ways to control weight?			If Yes: explain
	Do you / have you engaged in high risk sexual activity?			Yes No
	Do you have any concerns about sexually transmitted infections?			Yes No

	Do you use Tobacco (chew or smoke)?	NO	YES
	How many times in the past year have you used an illegal drug or used a prescription medication for non medical reasons?	0 to 1	> 1
	Do you use Marijuana (any form) or other Recreational Drugs?	NO	YES
	Are you in close contact with anyone using Marijuana / Recreational Drugs?	NO	YES
	I prefer to discuss this section with the official Team Physician or Therapist.	NO	YES

Training History

	How old were you when you became active in competitive Sports?	Age
	How many hours do you train for your sport per week ?	Hours
	How many hours do you train beyond normal training times for your sport? (ie on your own time outside of the structured practice training hours set)	Hours / week

Student #:

	Nutritional and Supplements Review	No Never	In past Not now	Yes now
	Do you use Ephedrine or any other energy boosters / weight cutters?			
	Do you use Protein or Creatine or NO or any other Weight Gainers?			
	Do you use energy drinks? (Red Bull, Rock Star, Etc)			
	Do you use anabolic steroids or steroids of any sort?			
	Do you use any Anabolic Steroids Pre-Cursors? (Andro, DHE, Etc)			
	Do you use any other hormones? (HGH, Insulin, Thyroxine, Etc)			
	Do you use anything promising to increase/decrease weight/energy?			
	Do you take anything to enhance recovery from training?			
	Are you 100% sure of the contents of everything you are taking?			
	Are you 100% sure of the CCES status of everything you take?			
	What formal Drug & Sport (Doping) presentations have you had?	NONE	On-Line	OTHER
	Explain:			
	Are you aware of the Global Drug Reference online tool			

Medications and Allergies:

Have you taken **ANY** prescription medications or other substances in past 3 months? **YES** **NO**
(Any liquids, inhalations, injections, ointments, patches, pills, powders, etc.)
(Any herbal- homeopathic-natural remedies, vitamins or over-the-counter substances, etc.)

IF YES - please list below:

SUBSTANCE	REASON	PAST 3 MONTHS	CURRENT	PRESCRIBER (MD, Other Medical, Parent, Coach, Trainer, Friend, Team Mate, Internet Etc)

Do you have any significant food, environmental or medical drug allergies? YES / NO

IF YES - please list below:

SUBSTANCE	LAST EPISODE	TYPE OF REACTION

X) **Please use this space to expand on any questionnaire items or for issues you feel we should know:**

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Personal health information may be used only for the purposes for which it was collected, except with patient consent or as required by law. By acknowledging and agreeing, Health Services at Western, Fowler/Kennedy Sport Medicine Clinic and the Head Athletic Therapist for Sport and Recreation Services, Western may need to share relevant health information. All health information will be kept confidential, stored and secured to protect your privacy.

I acknowledge and consent to Health Services at Western, Fowler Kennedy Sport Medicine Clinic and the Head Athletic Therapist for Sport and Recreation Services, Western University sharing relevant health information.

Athlete Signature: _____ Date: _____