

University of Delaware

- Right Handed
- Left Handed

Sports Medicine Clinic Preparticipation Questionnaire

The University of Delaware requires a medical examination by a Student Health Service physician prior to participation in the intercollegiate athletic program. Please complete the following.

NAME:

AGE:

BIRTHDATE:

SPORT:

POSITION:

- | | YES | NO | |
|----|--------------------------|--------------------------|---|
| 1. | <input type="checkbox"/> | <input type="checkbox"/> | Has a doctor ever denied or restricted your participation in sports for any reason? |
| | <input type="checkbox"/> | <input type="checkbox"/> | Do you have an ongoing medical condition? (like diabetes or asthma) |
| | <input type="checkbox"/> | <input type="checkbox"/> | Have you had an illness or injury since your last checkup or physical? |
| | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been hospitalized overnight? |
| | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any surgery or operations, even minor one? (tonsillectomy, appendectomy) |
| | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had an injury that caused limitation of activity or required medical attention? |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | Are you currently taking any prescription or non-prescription (over-the-counter) medicines or pills? |
| | <input type="checkbox"/> | <input type="checkbox"/> | Do you take any supplements or vitamins? |
| | <input type="checkbox"/> | <input type="checkbox"/> | Are you allergic to any medications, stinging insects, foods, plants or pollen? |
| | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a rash or hives develop during or after exercise? |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any skin problems? (itching, rashes, acne, herpes, eczema, warts, fungus or blisters) |
| | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been told you have asthma? |
| | <input type="checkbox"/> | <input type="checkbox"/> | Do you cough, wheeze, or have trouble breathing during or after exercise? |
| | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had discomfort, pain or pressure in your chest during exercise? |
| | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had infectious mononucleosis? (mono) |
| 4. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever felt dizzy or passed out during or after exercise? |
| | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had chest pain during or after exercise? |
| | <input type="checkbox"/> | <input type="checkbox"/> | Do you tire more quickly than your friends during exercise? |
| | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had the feeling of your heart racing or skipped beats during or after exercise? |
| | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been told you had high blood pressure or high cholesterol in your blood? |
| | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had an electrocardiogram (EKG) of your heart? |
| | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been told you have a heart murmur? |
| | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a heart infection? |
| | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any family members or relatives that have died before age 50? |
| | <input type="checkbox"/> | <input type="checkbox"/> | When exercising in the heat, do you have severe muscle cramps or become ill? |
| | <input type="checkbox"/> | <input type="checkbox"/> | Has a doctor told you that you or someone in your family has sickle cell trait or disease? |
| | <input type="checkbox"/> | <input type="checkbox"/> | Are you missing any paired organs? (kidneys, testicles, eyes) |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a head injury? |
| | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a concussion or been knocked unconscious? |
| | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had seizures or convulsions? |
| | <input type="checkbox"/> | <input type="checkbox"/> | Do you have recurrent or frequent headaches? |
| | <input type="checkbox"/> | <input type="checkbox"/> | Do you have headaches with exercise/weight lifting? |
| | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had numbness or tingling in your arms or legs after hitting another player? |
| | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been unable to move your arms or legs after being hit or falling? |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | Do you require any special equipment?
(braces, neck rolls, dental, orthotics, hearing aids, athletic cups) |
| | <input type="checkbox"/> | <input type="checkbox"/> | Do you wear jewelry that you do not remove during competition? |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any problems with your eyes or vision? |
| | <input type="checkbox"/> | <input type="checkbox"/> | Do you wear glasses, contact lens, or protective eyewear when you play? |

Please explain "YES" answers here:

NAME: _____

- YES NO
8. Have you had a tetanus booster within the last 10 years? When? _____
 Have you received your measles booster shot?
 Have you received the hepatitis immunization series (all three shots)?
9. Have you ever sprained/strained, dislocated, fractured/broken or other injuries to other bones/joints?
 Do you get shoulder pain when you throw, serve or swim?
 Have you ever had a shoulder separation or shoulder subluxation/dislocation?
 Have you ever had an elbow or hand injury?
 Have you ever had upper back pain or lower back pain?
 Do you have any hernias, pelvic or groin pain?
 Have you ever had pain or swelling in or around your knee (or any other body part)?
 Have you had any ankle sprains, swelling or weakness?
 Have you ever had shin splints or stress fractures?
 Do you have painful feet (callous/bunions) or flat feet?
 Do you wear a brace or tape for participation?
 Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below.

Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/Fingers	Chest
Upper Back	Lower Back	Hip	Thigh	Knee	Calf/Shin	Ankle	Foot/Toes

10. Are you aware of any reason why you should not participate in the UD athletic program at this time?
11. Can you swim?

Please explain "YES" answers here: _____

THE UNDERSIGNED, HEREWITH:

- A. Understands that he or she must refrain from practice or play while ill or injured, whether or not receiving medical treatment, and during medical treatment until he or she is discharged from treatment or is given permission by the clinical practitioner to restart participation despite continuing treatment.
- B. Understands that having passed the physical examination does not necessarily mean that he or she is physically qualified to engage in athletics, but only that the evaluator did not find a medical reason to disqualify him or her at the time of said examination.
- C. Certifies that the answers to the questions above are correct or true.

Date: _____ Time: _____
 Student's Signature: _____ SHS Signature: _____

RELEASE OF INFORMATION:

I hereby authorize the Student Health Service to release to the coach and/or trainer any information on my athletic physical examination or recertification relevant or pertinent to my participation in sports. I also hereby authorize the Student Health Service/Sports Medicine Clinic to release to the Associate Athletic Director any information acquired in the course of my treatment for injuries/illnesses during my participation in sports at the University of Delaware for the purpose of determining the extent of the institution's liability.

Date: _____ Time: _____
 Student's Signature: _____ SHS Signature: _____
 Parent/Guardian's Signature (if under 18 years old): _____

PARENT'S OR GUARDIAN'S PERMISSION TO TREAT AND RELEASE (ATHLETES UNDER 18 YEARS OLD)

I hereby give my consent for the above student to engage in approved athletic activities as a representative of her/his school. I also give permission for the team physician, athletic trainers, or other qualified personnel to administer first aid treatment to this student at an athletic event in case of injury.

Date: _____ Time: _____
 Parent/Guardian's Signature: _____ SHS Signature: _____

Additional Questions (All questions are strictly confidential and will not be shared with parents or coaches):

- | | YES | NO | |
|-----|--------------------------|--------------------------|--|
| 11. | <input type="checkbox"/> | <input type="checkbox"/> | Do you smoke cigarettes, use smokeless tobacco, or use tobacco in any form? |
| | <input type="checkbox"/> | <input type="checkbox"/> | Do you use alcohol, and if yes, how often? |
| | <input type="checkbox"/> | <input type="checkbox"/> | Have you used marijuana, cocaine, or any "street" recreational drugs? |
| | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any questions regarding drugs, tobacco, or alcohol? |
| | <input type="checkbox"/> | <input type="checkbox"/> | Do you feel stressed out, and if yes, do you feel you get the necessary support to deal with your stress? |
| | <input type="checkbox"/> | <input type="checkbox"/> | Is there anyone in your family who regularly uses alcohol, cocaine, marijuana, or other drugs or has undergone treatment for alcohol-or drug-related problems? |
| 12. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been sexually active? |
| | <input type="checkbox"/> | <input type="checkbox"/> | Are you presently sexually active? |
| | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any body piercing or tattoos? |
| 13. | <input type="checkbox"/> | <input type="checkbox"/> | Are you satisfied with your eating patterns? |
| | <input type="checkbox"/> | <input type="checkbox"/> | Have you had a weight change (loss or gain) of over 10 lbs. this year? |
| | <input type="checkbox"/> | <input type="checkbox"/> | Are you a vegetarian? If yes, how do you get your daily protein? _____ |
| | <input type="checkbox"/> | <input type="checkbox"/> | Do you lose weight regularly to participate in your sport? |
| | <input type="checkbox"/> | <input type="checkbox"/> | Do you want to weigh more or less than you presently do? |
| | <input type="checkbox"/> | <input type="checkbox"/> | Have you restricted your food intake due to concerns about your weight or body size? |
| | <input type="checkbox"/> | <input type="checkbox"/> | Have you had a history of anorexia, bulimia (forced vomiting), or any other eating disorder? |
| | <input type="checkbox"/> | <input type="checkbox"/> | Have you used binge eating, vomiting, diet pills, sitting in a sauna, laxative use, diuretics (water pills), or similar techniques as a means of weight control? |
| | <input type="checkbox"/> | <input type="checkbox"/> | Would you like to meet with a dietitian to discuss your nutritional needs or eating habits? |

(FEMALES ONLY!)

- | | | | |
|-----|--------------------------|--------------------------|---|
| 15. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have painful or heavy periods? |
| | <input type="checkbox"/> | <input type="checkbox"/> | Have you had all 12 periods in the past year? If not, how many periods have you had in the past year? _____ |
| | <input type="checkbox"/> | <input type="checkbox"/> | Do you take any medications during your periods? |
| | <input type="checkbox"/> | <input type="checkbox"/> | Do you take birth control pills? If yes, what brand? _____ |
| | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any problems with your breasts? |
| | <input type="checkbox"/> | <input type="checkbox"/> | Have you had a pelvic examination within the last year? |
| | <input type="checkbox"/> | <input type="checkbox"/> | Would you like an appointment with our university gynecology services? |

Please explain "YES" answers here:

PHYSICAL EXAMINATION

Height _____ Weight _____ % body fat (optional) _____ Pulse _____ BP _____/_____/_____,
 BP _____/_____/_____

Vision R 20/___ L 20/___ Corrected: Y N Hearing: (see below)

AudioScope Screening Results

Y = Response N = No Response

Right Ear _____

Left Ear _____

500	1000	2000	4000	Frequency (Hz)
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