



PRE-PARTICIPATION HEALTH HISTORY

(Initial Participation in Intercollegiate Athletics at UCSC)

University of California, Santa Cruz

Name: _____ Date: _____

Sport: _____ Date of Birth: _____

Local UCSC Address: _____
Street City, State, & Zip Code

UCSC Student ID#: W _____ Cell Phone #: _____

Date of last physical exam by a physician: _____ Home Phone #: _____

Date of last tetanus booster: _____

- | | YES | NO |
|--|-----|----|
| a. Have you been under a physician care in the past 12 months? | YES | NO |
| b. Have you been in the hospital in the past 12 months? | YES | NO |
| c. Have you had any type of surgery? | YES | NO |
| d. Do you wish to talk to a doctor about a health problem or injury? | YES | NO |

Explain all "yes" answers: _____

- | | YES | NO |
|----------------------------------|-----|----|
| Have you ever had or now have: | | |
| Concussion (head injury) | YES | NO |
| A skull fracture | YES | NO |
| Convulsion or epilepsy | YES | NO |
| A neck injury | YES | NO |
| A stinger, burner, pinched nerve | YES | NO |

Explain all "yes" answers: _____

- | | YES | NO |
|--|-----|----|
| e. Has anyone in your immediate family ever had: | | |
| Diabetes (high blood pressure) | YES | NO |
| Hives or rashes | YES | NO |
| a Stroke | YES | NO |
| Heart Trouble | YES | NO |
| High Blood Pressure | YES | NO |
| High Cholesterol | YES | NO |
| Epilepsy | YES | NO |
| Sickle cell anemia (trait) | YES | NO |
| Osteoporosis | YES | NO |

For each "yes" answer, identify the family member, the condition, & age: _____

- | | YES | NO |
|-------------------------------------|-----|----|
| k. Have you had or do you now have: | | |
| To wear glasses or contacts | YES | NO |
| Impaired vision in one eye | YES | NO |
| Temporary loss of vision | YES | NO |
| Hearing loss | YES | NO |
| a perforated eardrum | YES | NO |
| Recurrent ear infections | YES | NO |

- | | YES | NO |
|-------------------------------------|-----|----|
| l. Have you had or do you now have: | | |
| a broken nose | YES | NO |
| Sinus infections | YES | NO |
| Nose bleeds | YES | NO |
| a dental plate or dentures | YES | NO |
| Orthodontia (braces) | YES | NO |

Explain all "yes" answer: _____

- | | YES | NO |
|--|-----|----|
| f. Has anyone in your family, under age 50, died suddenly? | YES | NO |

Explain: _____

- | | YES | NO |
|---|-----|----|
| g. Have you ever had a problem with drugs or alcohol? | YES | NO |

Explain: _____

- | | YES | NO |
|-------------------------------------|-----|----|
| h. Have you ever had a heat illness | YES | NO |

Explain: _____

- | | YES | NO |
|--|-----|----|
| i. Have you had or do you have: | | |
| a hernia | YES | NO |
| Kidney problems | YES | NO |
| Loss of a kidney | YES | NO |
| Loss of function or absence of a testicle (men only) | YES | NO |
| a stomach or peptic ulcer | YES | NO |
| Migraine headaches | YES | NO |

- | | YES | NO |
|-------------------------------------|-----|----|
| m. Have you had or do you now have: | | |
| Diabetes | YES | NO |
| a tendency to bruise easily | YES | NO |
| Anemia | YES | NO |
| Thyroid trouble | YES | NO |
| Mononucleosis | YES | NO |
| Hepatitis | YES | NO |
| Tuberculosis | YES | NO |
| Gonorrhea or Syphilis | YES | NO |

Explain all "yes" answers: _____

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n. Have you had or do you now have:

Weight problems	YES	NO
Disordered eating	YES	NO
Dieting problems	YES	NO

Explain all "yes" answers: _____

o. Have you had or do you now have:

Hay fever	YES	NO
Exercised induced asthma	YES	NO
Asthma	YES	NO
Allergies to bites/ stings	YES	NO
an Epi pen	YES	NO
an inhaler	YES	NO

p. Are you allergic to:

Penicillin	YES	NO
Other medications	YES	NO
Any food	YES	NO
Latex	YES	NO
Ice (cold) application	YES	NO
Other substances	YES	NO

Explain all "yes" answers: _____

q. Do you:

Smoke	YES	NO
Take any medications regularly	YES	NO
Take any medications for emergency use	YES	NO

If YES, name of medication (s): _____

Females Only:

Age at onset of Menstruation: _____

Have you ever had or do you now have:

Amenorrhoea (loss of period)	YES	NO
Oligomenorrhoea (irregular period)	YES	NO
Dysmenorrhoea (very painful period, cramping)	YES	NO
Endometriosis	YES	NO
Implanted uterine device/Depo-provera	YES	NO

Do you currently use:

Birth control pills	YES	NO
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Name/Brand of birth control pills: _____

Date of last menstrual period: _____

How many periods have you had in the last year? _____

Date of last women's health exam: _____

r. Have you had or do you now have:

a persistent cough	YES	NO
a tendency to faint	YES	NO
Dizziness/faintness with exercise	YES	NO
Chest pain/discomfort with exercise	YES	NO
High blood pressure:	YES	NO
Heart trouble of murmur	YES	NO

s. Have you had or do you now have:

a recurrent rash	YES	NO
a fungal infection	YES	NO
Athlete's foot	YES	NO
Recurrent boils (skin infections)	YES	NO

Explain all "yes" answers: _____

t. Have you ever had an Electrocardiogram (EKG)

YES	NO
-----	----

Explain: _____

u. Do you wish to discuss emotional problems with a doctor?

YES	NO
-----	----

v. Do you have a loss of a paired organ?

YES	NO
-----	----

Explain: _____

w. Have you ever been told to give up sports because of a health problem

YES	NO
-----	----

Explain: _____

x. Do you use any special equipment (pads, braces, neck rolls, mouth guards, eye guards, etc)?

YES	NO
-----	----

Explain: _____

y. Do you take any vitamins? Please list. _____

z. Do you take any supplements or herbs? Please list. _____

I Hereby state that to the best of my knowledge my answers to the above questions are complete and correct.

Student-Athlete Signature

Date

Signature of Parent/Guardian (If under 18 years)

Date

Please keep a copy of these documents for your records.

For the following questions, be as specific as possible. Detail WHAT happened, WHEN it happened, RIGHT or LEFT, casted or immobilized, how long, any rehabilitation, Doctor's name and city.

- YES NO 1. Have you had a finger, hand, or wrist injury? _____

- YES NO 2. Have you had a sprain, dislocation, fracture, or other injury to the forearm or elbow? _____

- YES NO 3. Have you had a shoulder dislocation, separation, or other injury? _____

- YES NO 4. Have you had an injury to your hip or pelvis area? _____

- YES NO 5. Have you had knee arthroscopy or surgery? What other injuries have you had to your knees? _____

- YES NO 6. Have you experienced a severe ankle sprain or injury to your foot or ankle? _____

- YES NO 7. Have you had an injury to your upper or lower back? _____

- YES NO 8. Do you experience pain in your back? Seldom _____ Occasionally _____ Frequently _____
- YES NO 9. Do you wear orthotics in your shoes? Why? Who prescribed them and when? _____

- YES NO 10. Have you had any problems with muscle strains (pulls)? _____

- YES NO 11. Have you had any other significant injuries? _____

- YES NO 12. Have you had any other operations in the past five years? Explain in detail: _____

- YES NO 13. Are you currently on prescribed medication? Indicate drug, doctor, why it was prescribed and dosage. _____

- YES NO 14. Are you currently under the care of a physician? Give length of time and reason for care. _____

I have read and answered all of the above questions completely and truthfully to the best of my knowledge.

Student-Athlete Signature

D
a
t
e

Parent/Guardian Signature (if under 18 years)

Date

ATC Reviewed: _____

Please keep a copy of these documents for your records.