University of Delaware

Sports Medicine Clinic
Preparticipation Questionnaire

☐ Right Handed
☐ Left Handed

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.	☐	☐	Has a doctor ever denied or restricted your participation in sports for any reason?
	☐	☐	Do you have an ongoing medical condition? (like diabetes or asthma)
	☐	☐	Have you had an illness or injury since your last checkup or physical?
	☐	☐	Have you ever been hospitalized overnight?
	☐	☐	Have you had any surgery or operations, even minor one? (tonsillectomy, appendectomy)
	☐	☐	Have you ever had an injury that caused limitation of activity or required medical attention?
2.	☐	☐	Are you currently taking any prescription or non-prescription (over-the-counter) medicines or pills?
	☐	☐	Do you take any supplements or vitamins?
	☐	☐	Are you allergic to any medications, stinging insects, foods, plants or pollen?
	☐	☐	Have you ever had a rash or hives develop during or after exercise?
	☐	☐	Have you ever been treated for or diagnosed with ADD/ADHD?
3.	☐	☐	Do you have any skin problems? (itching, rashes, acne, herpes, eczema, warts, fungus or blisters)
	☐	☐	Have you ever been told you have asthma?
	☐	☐	Do you cough, wheeze, or have trouble breathing during or after exercise?
	☐	☐	Have you ever had discomfort, pain or pressure in your chest during exercise?
	☐	☐	Have you ever had infectious mononucleosis? (mono)
4.	☐	☐	Have you ever felt dizzy or passed out during or after exercise?
	☐	☐	Have you ever had chest pain during or after exercise?
	☐	☐	Do you tire more quickly than your friends during exercise?
	☐	☐	Have you ever had the feeling of your heart racing or skipped beats during or after exercise?
	☐	☐	Have you ever been told you had high blood pressure or high cholesterol in your blood?
	☐	☐	Have you ever had an electrocardiogram (EKG) of your heart?
	☐	☐	Have you ever been told you have a heart murmur?
	☐	☐	Have you ever had a heart infection?
	☐	☐	Do you have any family members or relatives that have died before age 50?
	☐	☐	When exercising in the heat, do you have severe muscle cramps or become ill?
	☐	☐	Has a doctor told you that you or someone in your family has sickle cell trait or disease?
	☐	☐	Are you missing any paired organs? (kidneys, testicles, eyes)
5.	☐	☐	Have you ever had a head injury?
	☐	☐	Have you ever had a concussion or been knocked unconscious?
	☐	☐	Have you ever had seizures or convulsions?
	☐	☐	Do you have recurrent or frequent headaches?
	☐	☐	Do you have headaches with exercise/weight lifting?
	☐	☐	Have you ever had numbness or tingling in your arms or legs after hitting another player?
	☐	☐	Have you ever been unable to move your arms or legs after being hit or falling?
6.	☐	☐	Do you require any special equipment? (braces, neck rolls, dental, orthotics, hearing aids, athletic cups)
	☐	☐	Do you wear jewelry that you do not remove during competition?
7.	☐	☐	Do you have any problems with your eyes or vision?
	☐	☐	Do you wear glasses, contact lens, or protective eyewear when you play?

Please explain "YES" answers here:

_____

_____

_____

_____

	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?
	☐	☐	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: _____
_____
_____

AGREEMENT TO PARTICIPATE IN INTERCOLLEGIATE ATHLETICS

Because of the dangers of participating in the above sport, I recognize the importance of following all instructions by the University of Delaware Athletics personnel. I understand and accept that I have the responsibility to report any and all injuries and illnesses, including signs and symptoms of concussions, to the medical staff at the University of Delaware. I have been presented with educational materials on concussions and understand that the University of Delaware Intercollegiate Athletic Program has a strict concussion management plan in place. I agree that I have been given the opportunity to ask questions about the concussion management plan and all other University of Delaware Athletics medical policies.

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

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.

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

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.

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

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.

SHS Parent/Guardian Signature:_____ Date:_____ Time:_____ SHS Initial:___

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

	YES	NO	
12.	☐	☐	Do you smoke cigarettes, use smokeless tobacco, or use tobacco in any form?
	☐	☐	Do you use alcohol, and if yes, how often?
	☐	☐	Have you used marijuana, cocaine, or any "street" recreational drugs?
	☐	☐	Do you have any questions regarding drugs, tobacco, or alcohol?
	☐	☐	Do you feel stressed out, and if yes, do you feel you get the necessary support to deal with your stress?
	☐	☐	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?
13.	☐	☐	Have you ever been sexually active?
	☐	☐	Are you presently sexually active?
	☐	☐	Do you have any body piercing or tattoos?
14.	☐	☐	Are you satisfied with your eating patterns?
	☐	☐	Have you had a weight change (loss or gain) of over 10 lbs. this year?
	☐	☐	Are you a vegetarian? If yes, how do you get your daily protein?_____
	☐	☐	Do you lose weight regularly to participate in your sport?
	☐	☐	Do you want to weigh more or less than you presently do?
	☐	☐	Have you restricted your food intake due to concerns about your weight or body size?
	☐	☐	Have you had a history of anorexia, bulimia (forced vomiting), or any other eating disorder?
	☐	☐	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?
	☐	☐	Would you like to meet with a dietitian to discuss your nutritional needs or eating habits?

(**FEMALES ONLY**!)

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

Please explain "YES" answers here:

_____
_____
_____
_____

PHYSICAL EXAMINATION

Height_____ Weight_____ % body fat (optional)_____ Pulse_____ 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)