



UC Irvine Sports Medicine Athletics Participation History



Name: _____ Date of Birth: _____ Sport: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

The following questions are to be answered by either YES or NO, Please offer a written explanation of each YES on page 2.

Have you had or do you now have:	Yes	No	Have you had or do you now have:	Yes	No
• Seasonal allergies?	<input type="checkbox"/>	<input type="checkbox"/>	• Very bad (impaired) vision in one eye?	<input type="checkbox"/>	<input type="checkbox"/>
• Asthma (wheezing)?	<input type="checkbox"/>	<input type="checkbox"/>	• Missing vision in one eye?	<input type="checkbox"/>	<input type="checkbox"/>
• Hay Fever?	<input type="checkbox"/>	<input type="checkbox"/>	• Temporary loss of vision?	<input type="checkbox"/>	<input type="checkbox"/>
• Hives or Rash (With or Without exercise)?	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear glasses or contacts?	<input type="checkbox"/>	<input type="checkbox"/>
• Bee-sting allergy?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had or do you now have:		
• Reaction to medicine?	<input type="checkbox"/>	<input type="checkbox"/>	• Hearing Loss?	<input type="checkbox"/>	<input type="checkbox"/>
• Food allergies?	<input type="checkbox"/>	<input type="checkbox"/>	• Perforated eardrum?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been under a doctor's care since you last physical?	<input type="checkbox"/>	<input type="checkbox"/>	• Chronic discharge from the ear(s)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been in the hospital since your last physical?	<input type="checkbox"/>	<input type="checkbox"/>	• Recurrent ear(s) infection(s)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any type of surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had or do you now have:		
			• Loss of function or absence of a testicle(men)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you or anyone in you immediate family ever had:	Yes Self	Yes Family	• Loss of Any other Organ?	<input type="checkbox"/>	<input type="checkbox"/>
			• Kidney problem or loss of a kidney?	<input type="checkbox"/>	<input type="checkbox"/>
• Headaches (severe, frequent, migraine)?	<input type="checkbox"/>	<input type="checkbox"/>	• Hernia?	<input type="checkbox"/>	<input type="checkbox"/>
• Heart trouble, murmur, racing heart?	<input type="checkbox"/>	<input type="checkbox"/>	• Persistent cough?	<input type="checkbox"/>	<input type="checkbox"/>
• High Blood Pressure?	<input type="checkbox"/>	<input type="checkbox"/>	• Diabetes (high sugar in blood or urine)?	<input type="checkbox"/>	<input type="checkbox"/>
• Sickle cell trait or disease?	<input type="checkbox"/>	<input type="checkbox"/>	• History of Mono?	<input type="checkbox"/>	<input type="checkbox"/>
• Marfan's Syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	• Tendency to bleed or bruise easily?	<input type="checkbox"/>	<input type="checkbox"/>
• History of heart disease?	<input type="checkbox"/>	<input type="checkbox"/>	• Anemia ("tired blood")?	<input type="checkbox"/>	<input type="checkbox"/>
• Seizure disorders?	<input type="checkbox"/>	<input type="checkbox"/>	• Unusual Fatigue?	<input type="checkbox"/>	<input type="checkbox"/>
Family history of a disabling heart / lung condition?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had or do you now have:	<input type="checkbox"/>	<input type="checkbox"/>
Has anyone in your family, under the age of 50, died suddenly?	<input type="checkbox"/>	<input type="checkbox"/>	• Sinus infections?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had or do you now have:			• Dental plate/dentures?	<input type="checkbox"/>	<input type="checkbox"/>
• Chest pain or discomfort with exercise?	<input type="checkbox"/>	<input type="checkbox"/>	• Orthodontics (teeth straightened)?	<input type="checkbox"/>	<input type="checkbox"/>
• Ever felt like you were going to pass out while working out?	<input type="checkbox"/>	<input type="checkbox"/>	• Do you have a Bridge of False Teeth?	<input type="checkbox"/>	<input type="checkbox"/>
• Shortness of breath while playing or exercising?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had or do you now have:		
• Dizziness or Faintness with exercise?	<input type="checkbox"/>	<input type="checkbox"/>	• Recurrent rash?	<input type="checkbox"/>	<input type="checkbox"/>
Any history of heat stroke or heat exhaustion?	<input type="checkbox"/>	<input type="checkbox"/>	• Fungus infection?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had or do you now have:			• Athlete's foot?	<input type="checkbox"/>	<input type="checkbox"/>
• Brain concussion / Knocked out?	<input type="checkbox"/>	<input type="checkbox"/>	• Recurrent boils (skin infections)?	<input type="checkbox"/>	<input type="checkbox"/>
• A hit or blow to the head that caused confusion, prolonged headache or memory problems?	<input type="checkbox"/>	<input type="checkbox"/>	• A history of Staph Infection?	<input type="checkbox"/>	<input type="checkbox"/>
• Head injury or facial/skull fracture?	<input type="checkbox"/>	<input type="checkbox"/>	• A history of MRSA?	<input type="checkbox"/>	<input type="checkbox"/>
• History of Migraines?	<input type="checkbox"/>	<input type="checkbox"/>	Any history of Attention Deficit Disorder (ADD) or ADHD?	<input type="checkbox"/>	<input type="checkbox"/>
• Number of previous Concussions	_____	_____	• Taking Medication for ADD/ADHD?	<input type="checkbox"/>	<input type="checkbox"/>
• Date of most recent concussion:	_____	_____	Any history of Learning Disabilities?	<input type="checkbox"/>	<input type="checkbox"/>
• Number of days missed after Concussion	_____	_____	Do you want to talk to a doctor about a health problem or an injury?	<input type="checkbox"/>	<input type="checkbox"/>
			Do you wish to discuss an emotional problem with the doctor?	<input type="checkbox"/>	<input type="checkbox"/>

Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	Do you eat three meals a day?	<input type="checkbox"/>	<input type="checkbox"/>
Family history of smoking?	<input type="checkbox"/>	<input type="checkbox"/>	Do you drink at least (8) 12 oz glasses of water/day?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a problem with:	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to gain weight?	<input type="checkbox"/>	<input type="checkbox"/>
• Alcohol or drug abuse?			Are you trying to lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, past or present?	_____		Any history of Disordered Eating?	<input type="checkbox"/>	<input type="checkbox"/>
Family history of drug or alcohol abuse?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever tried to lose weight by:		
Take any medicine regularly (Over The Counter, prescription or for emergencies)?	<input type="checkbox"/>	<input type="checkbox"/>	• Dieting?	<input type="checkbox"/>	<input type="checkbox"/>
<i>If Yes, name medication(s):</i>	_____		• Vomiting?	<input type="checkbox"/>	<input type="checkbox"/>
_____			• Using Laxatives?	<input type="checkbox"/>	<input type="checkbox"/>
_____			• Using Diuretics?	<input type="checkbox"/>	<input type="checkbox"/>
Take any vitamins, or supplements? If yes, list below:	<input type="checkbox"/>	<input type="checkbox"/>	Any History of Stress Fracture?	<input type="checkbox"/>	<input type="checkbox"/>
_____			Had a sprain, strain or swelling after injury that has kept you from participation in practices/games?	<input type="checkbox"/>	<input type="checkbox"/>
_____			Identify below any location(s) with history of pain or swelling in muscles tendons, bones or joints?		
Have you ever been seen by a Heart Specialist?	<input type="checkbox"/>	<input type="checkbox"/>	<i>If yes, check the appropriate boxes corresponding to the body part and explain below:</i>		
<i>If Yes: Who: _____</i>			<input type="checkbox"/> Head	<input type="checkbox"/> Elbow	<input type="checkbox"/> Hip
<i>When: _____</i>			<input type="checkbox"/> Neck	<input type="checkbox"/> Forearm	<input type="checkbox"/> Thigh
Have you ever had an EKG/ECG?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Back	<input type="checkbox"/> Wrist	<input type="checkbox"/> Knee
Have you ever had a stress (heart) test?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chest	<input type="checkbox"/> Hand	<input type="checkbox"/> Shin/Calf
Have you been told to give up sports because of a health problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Finger	<input type="checkbox"/> Ankle
Have you had or do you have any other medical problems or injuries not listed on this form?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Upper Arm		<input type="checkbox"/> Foot
<i>If Yes: _____</i>			Had numbness/tingling in arms, hands, legs or feet?	<input type="checkbox"/>	<input type="checkbox"/>
Are there any additional health problems you would prefer to discuss privately with our Team Physician?	<input type="checkbox"/>	<input type="checkbox"/>	Had a stinger, burner or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>
			So you use special protective or corrective equipment of devices? Knee sleeves, braces, etc.	<input type="checkbox"/>	<input type="checkbox"/>
			<i>If Yes: _____</i>		

If you have answered YES to any of the questions (page 1 & 2), please EXPLAIN below:

Women Only:		Do you experience cramps?	<input type="checkbox"/>	<input type="checkbox"/>
How old were you when you had your 1 st period?	_____	Have you been diagnosed or treated for anemia?	<input type="checkbox"/>	<input type="checkbox"/>
How long do your periods last?	_____	Do you have trouble with heavy bleeding?	<input type="checkbox"/>	<input type="checkbox"/>
How often do you have your periods?	_____	Do you take birth control pills or hormones?	<input type="checkbox"/>	<input type="checkbox"/>
How many periods have you had in the past 12 mo.?	_____	Have you ever had an abnormal PAP smear?	<input type="checkbox"/>	<input type="checkbox"/>
When was your last pelvic exam?	_____	Do you have frequent urinary tract infections?	<input type="checkbox"/>	<input type="checkbox"/>

Additional comments, information or questions?

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

Signature of Athlete: _____ Date: _____

Signature of Parent (if Under 18 at time of Physical): _____ Date: _____

Signature of UCI Team Physician _____ Date: _____

UCI Team Physician Print Name: _____