



Office Use Only
 B/P _____ Pulse _____ Ht _____ Wt _____
 Requires a physical exam prior to participation: Yes / No
 Reviewed by (Name) _____

ELON UNIVERSITY SPORTS MEDICINE

Interim Pre-participation History

This form is to evaluate your Health History since your last pre-participation exam or Interim questionnaire. The information below will be part of your **Confidential Medical Record**.

Name: _____ Date: _____

Sex: _____ Age: _____ Date of Birth: _____ Class: _____

Please list all sports: _____ Campus Phone: _____

Have you ever had a pre-participation physical exam at Elon University: (circle one) **Yes / No**

List any chronic illness or injury that requires ongoing or periodic medical supervision, medication, or other therapy? (for example asthma, diabetes, high blood pressure, or a cardiac condition) _____

List all other medical issues in the last year, include date of onset, and date of resolution; (for example mononucleosis; onset 2/1/03, resolution 4/1/03): _____

List all musculoskeletal injuries in the last year, include date of onset, date of resolution, and any residual problems (for example, R ankle sprain, onset 11/20/03, resolution 12/20/03, L knee tendonitis, onset 10/03, residual soreness after extended exercise) _____

Please list any medications (include over the counter medications, vitamins, supplements, birth control pills) _____

Please list any allergies (drug, food, animal, other) _____

Please list any new appliances (glasses, contacts, braces) _____

Please list any surgical operations or accidents in the past year? _____

Since your last exam, have you experienced chest pain, shortness of breath, dizziness, or fainting? Y / N

If yes, did this occur during or shortly after exercise? Y / N

Please give details & any evaluation _____

Have you had a head injury or loss of consciousness in the past year? Y / N

If yes, please give details & any evaluation _____

Please list any injuries which have occurred to the following body parts since your last exam at Elon Sports Medicine:

Foot / ankle _____ Date: _____

Shin / calf / thigh _____ Date: _____

Knee _____ Date: _____

Back / neck _____ Date: _____

Shoulder _____ Date: _____

Elbow / wrist / hand / fingers _____ Date: _____

Other _____ Date: _____

Please list any symptoms or other problems that have occurred in the following areas since your last exam:

Head / ears / eyes / nose / throat _____ Date: _____

Respiratory (lungs) / Cardiovascular _____ Date: _____

Gastrointestinal (abdomen, liver, pancreas, etc) _____ Date: _____

Genitourinary _____ Date: _____

Skin _____ Date: _____

Other _____ Date: _____

If you had an injury or an illness, was it evaluated by the Sports Medicine staff at Elon? () Yes () No

If you had an injury or an illness, have you recovered fully and returned to full play? () Yes () No

Do you know your sickle cell status? () Yes () No () Unsure

Have you in the past, or do you currently use, or have concerns about:

Yes No

() () Cigarettes, chewing tobacco, or marijuana? _____

() () Alcohol? _____

() () Recreational drugs (ecstasy, cocaine, heroin, etc)? _____

() () Steroids? _____

() () Vitamins or supplements? _____

Do you:

Yes No

() () Feel out of control when you are stressed?

() () Have a history of depression, or feel depressed?

() () Wear a seat belt 90% of the time?

() () Wear a bicycle / motorcycle helmet?

() () Understand & regularly perform a self-breast or self-testicular exam?

() () Practice safe sex?

() () Have a history of > 2 sexual partners in the last 6 months?

() () Have a history of any sexually transmitted disease?

() () Have any additional concerns or questions?

Nutritional concerns: Please provide additional comments for yes answers

What is your present weight? _____ Are you happy with your present weight? Y / N

If no, what is your desired weight? _____ How many meals do you eat each day? _____ Do you diet regularly? Y / N

Do you avoid certain food groups (carbohydrates, protein, meat, fats, salt, other)? Y / N Why?

Do you ever feel out of control of your eating patterns? Y / N

Have you tried to control your weight by: Excessive exercise? Y / N Dieting/Fasting? Y / N Vomiting? Y / N

Diet pills? Y / N Laxatives? Y / N Diuretics? Y / N

Have you ever had an eating disorder? Y / N

Have you in the past or are you currently being treated for an alcohol problem? Y / N

If you drink alcohol, answer the following questions, selecting the option that comes closest to your answer:

How often do you have an alcoholic drink?

Never/ <monthly /Monthly 2-4 X / mo 2-3 X / wk 4 or > / week

How many alcoholic drinks do you have on a typical day? 0, 1, or 2 - 3 to 5 - 6 to 8 - 10 or more

How often do you have 4 or more drinks on 1 occasion?

Never/ < monthly /Monthly /Weekly /Daily or almost daily

How often in the last year have you found you are unable to stop drinking once you've started?

Never/ < monthly /Monthly /Weekly /Daily or almost daily

How often in the last year have you failed to do what was normally expected of you because of drinking?

Never/ < monthly /Monthly /Weekly /Daily or almost daily

How often in the last year have you needed a drink in the morning to get yourself going after a heavy night of drinking?

Never/ < monthly /Monthly /Weekly /Daily or almost daily

How often during the last year have you felt guilty or been remorseful after drinking?

Never/ < monthly /Monthly /Weekly /Daily or almost daily

How often during the last year have you been unable to remember what happened the night before because of your drinking?

Never/ < monthly /Monthly /Weekly /Daily or almost daily

Have you or someone else been injured as a result of your drinking?

No / Yes, but not in the last year Yes, in the last year

Has a relative, friend, doctor or other health worker been concerned about your drinking or suggested you cut down?

No / Yes, but not in the last year Yes, in the last year

I, (Print Full Name) _____ declare that all of the above information is true to the best of my knowledge. If at any point, whether voluntary or involuntary, I leave the athletic program, I understand that I have 30 days to notify the Sports Medicine Staff of any injury/illness related to participation of intercollegiate athletics. Failure to do so will void the secondary insurance coverage supplied by Elon University Athletics.

Signature of Athlete _____ Date _____