University of California Santa Barbara Student Health Service

PREPARTICIPATION ATHLETIC CLEARANCE INITIAL HISTORY (1st of 2 PAGES)

You must bring a copy of your immunization record to the clearance exam.

NAME: **PERM #:** **SPORT:**

Explain "yes" answers below. Circle questions if you don't know the answers.

	Yes	No		Yes	No
1. Has a doctor ever denied or restricted your sports participation for any reason?			LUNG QUESTIONS 19. Has a doctor ever told you that you have asthma or allergies?		
2. Do you have an ongoing medical condition (like diabetes or asthma)?					
3. Have you ever been hospitalized or had a serious illness?			20. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
4. Were you born without or are you missing a kidney, spleen, testicle, or any other organ?			21. Have you ever used an inhaler or taken asthma medicines?		
5. Are you currently taking any prescription or nonprescription (over-the-counter) medicines, including birth control pills?			SKIN QUESTIONS 22. Have you had any rashes or other skin problems?		
6. Do you take any vitamins or supplements?			23. Have you had skin infections such as herpes, impetigo, or Staph (MRSA)?		
7. Do you have allergies to medicines, pollens, foods or stinging insects?			NEUROLOGY QUESTIONS 24. Have you ever had a head injury or concussion?		
HEART QUESTIONS 8. Have you ever passed out or nearly passed out DURING exercise?			25. Have you ever been hit in the head and been confused or lost your memory?		
			26. Have you ever had a seizure?		
9. Have you ever passed out or nearly passed out AFTER exercise?			27. Do you have headaches with exercise?		
10. Have you ever had discomfort, pain, or pressure in your chest during exercise?			28. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
11. Does your heart race or skip beats during exercise?			29. Have you ever been unable to move your arms or legs after being hit or falling?		
12. Has a doctor ever told you that you have (check all that apply): □ High blood pressure □ Heart murmur □ High cholesterol □ Heart infection	xx	xx	30. When exercising in the heat, have you ever had severe muscle cramps or become ill?		
13. Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram)			VISION QUESTIONS 31. Have you had any problems with your eyes or vision?		
FAMILY QUESTIONS 14. Has any family member or relative died of heart problems or of sudden and/or unexplained death before age 50?			32. Do you wear glasses or contact lenses?		
			33. Do you have any concerns that you would like to discuss with a doctor?		
15. Does anyone in your family have asthma?					
16. Does anyone in your family have a significant illness such as heart problems, diabetes, etc.?					
17. Does anyone in your family have Marfan's Syndrome?					
18. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?					

Explain "YES" answers here:

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PREPARTICIPATION ATHLETIC CLEARANCE INITIAL HISTORY (2nd of 2 PAGES)

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	YES	**NO**
MENTAL HEALTH QUESTIONS 34. Have you ever been severely depressed?		
35. Are you taking or have you ever taken medications for depression or other mental health problems?		
36. Have you ever received medical care or been hospitalized for mental health problems or an eating disorder?		
37. Have you ever been treated for Attention Deficit Hyperactivity Disorder (ADD or ADHD)?		
SUBSTANCE USE QUESTIONS 38. In an average week, how many alcoholic drinks will you have?_____	xxx	xxxx
39. Have you ever passed out or had memory blanks as a result of drinking?		
40. Have you ever felt like you ought to cut down on your drinking?		
41. Have you ever or do you currently smoke marijuana?		
42. Have you ever used other recreational drugs besides marijuana?		
WEIGHT QUESTIONS 43. Are you trying to gain or lose weight?		
44. Has anyone recommended you change your weight or eating habits?		
45. Do you limit or carefully control what you eat?		
FEMALES ONLY 46. How old were you when you had your first menstrual period?_____		
47. Have you ever missed a menstrual period?		
48. How many periods have you had in the last 12 months?_____		

ORTHOPEDIC QUESTIONS 49. Have you ever had a stress fracture?		
50. Have you been told that you have or have you had an X-ray for neck instability?		
51. Do you regularly use a brace or assistive device?		
52. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis that caused you to miss a practice or game?		
53. Have you had any broken or fractured bones or dislocated joints?		
54. Have you had a bone or joint injury that required X-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, cast or crutches?		

CIRCLE any area below that is INJURED currently or has been in the past:

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

Explain "YES" answers here:

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

PRINT NAME SIGNATURE PERM # DATE