Pacific Lutheran University

Club Sports Pre-Participation Medical History
2023-24 Academic Year

Date of exam: _____
Name _____ PLU ID: _____

Age _____ Sport(s): _____

■ Medicines and Allergies

Please list all of the prescription and over-the counter medicines and supplements (herbal and nutritional) that you are currently taking:

_____

Do you have any allergies? □ Yes □ No If yes, please identify specific allergies below:

□ Medicines □ Pollen □ Food □ Stinging insects

Explain all "Yes" answers below. Circle any question to which you do not know the answer. Please review these questions with your parent/guardian/healthcare provider so that you can answer with as much detail as possible.

■ General Questions	Yes	No
1. Has a healthcare provider ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify them below: □ Asthma □ Anemia □ Diabetes □ Infections □ Other _____		
3. Have you ever spent the night in the hospital		
4. Have you ever had surgery?	Yes	No
■ Heart Health Questions <u>About You</u>		
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a healthcare provider ever told you that you have any heart problems? If so, check all that apply: □ High blood pressure □ Heart murmur □ High cholesterol □ Heart infection □ Kawasaki Disease □ Other _____		
9. Has a healthcare provider ever ordered a test for your heart (such as an ECG/EKG or echocardiogram?		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
■ Heart Health Questions <u>About Your Family</u>	Yes	No
13. Has any family member or relative died of heart problems, or had an unexpected or unexplained sudden death <u>before age 50</u> (including drowning, unexplained car accident, or sudden infant death syndrome?)		

14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan Syndrome, arrythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		

Name _____ PLU ID _____

15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
■ Bone and Joint Concerns	Yes	No
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required an x-ray, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray to check for neck instability, atlantoaxial instability? (Down syndrome or dwarfism?)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		
■ Other Medical Questions		
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?	Yes	No
27. Have you ever used an inhaler or taken asthma medicine?		
28. Does anyone in your family have asthma?		
29. Were you born without—or are you missing—a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain, or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the past month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you ever had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of a seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		

41. Do you get frequent muscle cramps while exercising?		
42. Do you or does anyone in your family have sickle cell trait or sickle cell disease?		

Name _____ PLU ID _____		
43. Have you ever had any problems with your eyes or vision? (Other than wearing glasses or contacts)		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying—or has anyone recommended—that you gain or lose weight?		
49. Are you on a special diet, or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with the healthcare provider today?		
■ Mental Health		
52. Are you currently or have you ever been treated for mental health concerns, such as depression and anxiety?		
53. Would you like information about counseling services on campus?		
■ Females Only	Yes	No
54. Have you ever had a menstrual period?		
55. How old were you when you had your first menstrual period?		
56. How many periods have you had in the past 12 months?		

Please explain any "yes" answers here.

_____

_____

_____

■ Attestation and Consent

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

As a student and/or parent or legal guardian, I consent to a comprehensive medical examination, electrocardiography, and laboratory testing as required for athletic participation.

I also consent to have the information in this form shared with the PLU Athletic Department, as well as subsequent medical information that may affect my ability to participate in my sport for the duration of my participation at PLU in this Club sport. This may involve illness or injuries that occur both on and off the sports field.

There are no charges for the medical examination.

Student Signature _____ Date _____

Student printed name _____ PLU ID# _____

Parent/Guardian Signature (if student is under 18) _____ Date _____