



TRINITY WASHINGTON UNIVERSITY ATHLETICS
**PRE-PARTICIPATION MEDICAL
HISTORY**

PARTICIPATION WILL NOT BE ALLOWED UNTIL THIS FORM IS COMPLETED

LAST NAME	FIRST NAME	MIDDLE INITIAL(S)	
_____	_____	_____	
BIRTHDATE	AGE	SPORT(S)	ANTICIPATED GRADUATION YEAR
_____	_____	_____	_____

ATTENTION: ADHD medications require additional documentation per NCAA regulations. Please have the prescribing physician complete the following document and submit the outlined supplemental documentation: [NCAA ADHD Reporting Form](#)

NAME OF MEDICATION	REASON FOR USE	DOSAGE AND FREQUENCY

ATTENTION: Student-athletes are required to provide the Athletic Training Staff with an unexpired Epi-Pen, inhaler, diabetic medication, and/or any other life-saving medications.

Check if you use the following:

- Epi-Pen Inhaler Diabetic Medication Life-Saving Medication

Do you have any allergies? If yes, please specify below:

- Medicines Food Stinging Insects Pollen

Other: _____

MEDICAL QUESTIONS

YES	NO	1. Has a doctor ever denied or restricted your participation in sports?
YES	NO	2. Do you have any ongoing medical conditions? If so, please identify: <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections <input type="checkbox"/> Other:
YES	NO	3. Have you ever spent the night in the hospital?
YES	NO	4. Have you ever had surgery?
YES	NO	5. Have you ever been under the care of a psychologist, psychiatrist, or counselor?
YES	NO	6. Have you ever been diagnosed with anxiety, depression, or another mental health condition?
YES	NO	7. Do you cough, wheeze, or have difficulty breathing during or after exercise?
YES	NO	8. Have you ever used an inhaler or taken asthma medicine?
YES	NO	9. Is there anyone in your family who has asthma?
YES	NO	10. Were you born without or are you missing a kidney, eye, testicle, spleen, or any other organ?
YES	NO	11. Do you have groin pain or a painful bulge or hernia in the groin area?
YES	NO	12. Have you had infectious mononucleosis within the last month?
YES	NO	13. Do you have any rashes, pressure sores, or other skin problems?
YES	NO	14. Have you had a herpes or MRSA skin infection?
YES	NO	15. Have you ever had a head injury or concussion?
YES	NO	16. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?
YES	NO	17. Do you have a history of seizure disorder?
YES	NO	18. Do you have headaches with exercise?
YES	NO	19. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?
YES	NO	20. Have you ever been unable to move your arms or legs after being hit or falling?
YES	NO	21. Have you ever become ill while exercising in the heat?
YES	NO	22. Do you get frequent muscle cramps when exercising?
YES	NO	23. Have you had any problems with your eyes or vision?

YES	NO	24. Have you had any eye injuries?
YES	NO	25. Do you wear glasses or contact lenses?
YES	NO	26. Do you wear protective eyewear?
YES	NO	27. Do you worry about your weight?
YES	NO	28. Are you trying to or has anyone recommended that you gain or lose weight?
YES	NO	29. Are you on a special diet or do you avoid certain types of foods?
YES	NO	30. Have you ever had an eating disorder?
YES	NO	31. Do you have any concerns that you would like to discuss with a doctor?
YES	NO	32. <i>Females only:</i> Have you ever had a menstrual period?
YES	NO	33. <i>Females only:</i> How old were you when you had your first menstrual period?
YES	NO	34. <i>Females only:</i> How many periods have you had in the last 12 months?
YES	NO	35. Do you regularly use a brace, assistive device, or prosthetic?
YES	NO	36. Do you use any special brace or assistive device for sports?
YES	NO	37. Do you have rashes, pressure sores, or any other skin problems?
YES	NO	38. Do you have any hearing loss? Do you use a hearing aid?
YES	NO	39. Do you have a visual impairment?
YES	NO	40. Do you use any special devices for bowel or bladder function?
YES	NO	41. Do you have any burning or discomfort with urination?
YES	NO	42. Have you had autonomic dysreflexia?
YES	NO	43. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?
YES	NO	44. Do you have muscle spasticity?
YES	NO	45. Do you have frequent seizures or seizure-like activity that cannot be controlled by medication?

HEART HEALTH QUESTIONS ABOUT YOU

YES	NO	46. Have you ever passed out or nearly passed out during or after exercise?
YES	NO	47. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?

YES	NO	48. Does your heart ever race or skip beats (irregular beats) during exercise?
YES	NO	49. Do you ever get light-headed, feel more short of breath, or more tired than expected during exercise?
YES	NO	50. Has a doctor ever ordered a test for your heart?
YES	NO	51. Has a doctor ever told you that you have any heart problems such as a heart murmur, high blood pressure, etc.?
YES	NO	52. Have you ever had a seizure?
YES	NO	53. Have you ever passed out or nearly passed out during or after exercise?

HEART HEALTH QUESTIONS ABOUT YOUR FAMILY

YES	NO	54. Has any family member or relative died of heart problems, or had unexpected or unexplained sudden death before the age of 50?
YES	NO	55. Does anyone in your family have hypertrophic cardiomyopathy, Marfan Syndrome, long QT syndrome, or other ion channelopathies, or clinically important arrhythmias?
YES	NO	56. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?
YES	NO	57. Does any family member or relative under the age of 50 have disability from heart disease?

BONE AND JOINT QUESTIONS

YES	NO	58. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss practice or a game?
YES	NO	59. Have you ever had any broken or fractured bones or dislocated joints?
YES	NO	60. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?
YES	NO	61. Have you ever had a stress fracture?
YES	NO	62. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability (Down syndrome or dwarfism)?
YES	NO	63. Do you regularly use a brace, orthotics, or other assistive devices?
YES	NO	64. Do you have a bone, muscle, or joint injury that bothers you?
YES	NO	65. Do any of your joints become painful, swollen, feel warm, or look red?
YES	NO	66. Do you have any history of juvenile arthritis or connective tissue disease?

PLEASE STATE THE QUESTION NUMBER (1-66) FOLLOWED BY YOUR EXPLANATION FOR ANY "YES" ANSWER

Q # _____

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOUR CURRENT OR PAST MEDICAL HISTORY

- | | | |
|---|--|---|
| <input type="checkbox"/> Atlantoaxial instability | <input type="checkbox"/> Difficulty controlling bowel | <input type="checkbox"/> Weakness in legs or feet |
| <input type="checkbox"/> X-ray eval. for atlantoaxial instability | <input type="checkbox"/> Difficulty controlling bladder | <input type="checkbox"/> Recent change in coordination |
| <input type="checkbox"/> Dislocated joints | <input type="checkbox"/> Numbness or tingling in arms or hands | <input type="checkbox"/> Recent change in ability to walk |
| <input type="checkbox"/> Easy bleeding | <input type="checkbox"/> Numbness or tingling in legs or feet | <input type="checkbox"/> Spina bifida |
| <input type="checkbox"/> Enlarged spleen | <input type="checkbox"/> Weakness in arms or hands | <input type="checkbox"/> Latex allergy |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Weakness in legs or feet | <input type="checkbox"/> Osteopenia or osteoporosis |

PLEASE EXPLAIN ALL BOXES CHECKED ABOVE

I hereby state that to the best of my knowledge the answers provided are correct. I have not withheld any health information important to my safety and the safety of others. I have discussed my past medical and family history with my parents or guardians to ensure accuracy.

STUDENT-ATHLETE SIGNATURE

**PARENT / GUARDIAN SIGNATURE
(IF UNDER 18)**

DATE
