



Southwestern Oklahoma State University

Student-Athlete Health History Questionnaire Form

The information contained in this medical history form will only be used by the Athletic Training Staff of SWOSU for purposes of determining if you pose a health threat / risk to yourself on the athletic field. This information will remain CONFIDENTIAL at all times.

(please print clearly)

Name _____ Date _____

Student ID # _____ Date of Birth _____

Race: Caucasian Afro-American Hispanic Asian/Pacific Alaskan/Indian Other _____

Sport(s) _____ Position(s) _____

Height _____ Weight _____ Right Handed Left Handed

PERMANENT ADDRESS:

_____ STREET

_____ CITY STATE ZIP CODE

_____ PHONE 1 PHONE 2 (CELLULAR)

Father's Name _____

Age _____

If Deceased, Cause of Death _____

Age @ Death _____

Father's Occupation _____

Address (if different from permanent address):

_____ STREET

_____ CITY STATE ZIP CODE

_____ HOME PHONE WORK PHONE

Mother's Name _____

Age _____

If Deceased, Cause of Death _____

Age @ Death _____

Mother's Occupation _____

Address (if different from permanent address):

_____ STREET

_____ CITY STATE ZIP CODE

_____ HOME PHONE WORK PHONE

I. Cardiovascular Risk Factors:

- Have you ever had chest pain and/or shortness of breath during or after exercise / practice? YES NO
 ♦ Please Describe _____
- Have you ever felt dizzy, lightheaded, and/or passed out during or after exercise / practice? YES NO
 ♦ Please Describe _____
- Have you ever had the feeling of your heart racing or skipping beats during or after exercise / practice? YES NO
 ♦ Please Describe _____
- Do you get tired more quickly than your teammates / friends do during exercise / practice? YES NO
 ♦ Please Describe _____
- Have you ever been told that you have a heart murmur? YES NO
 ♦ Please Describe _____
- Has any family member or relative died of heart problems and/or of sudden death before age 50? YES NO
 ♦ Please Describe _____
- Has a physician ever denied or restricted your participation in sports due to any heart / cardiovascular problems? YES NO
 ♦ Please Describe _____
- Have you ever had an electrocardiogram (EKG) and/or echocardiogram (ECHO) of your heart? YES NO
 ♦ Dates / Please Describe _____
- Does anyone in your family have a history of high blood pressure? YES NO
 ♦ Please Describe _____
- Have you ever been told that you have / had high blood pressure? YES NO
 ♦ Please Describe _____
- Does anyone in your family have a history of high blood cholesterol? YES NO
 ♦ Please Describe _____
- Have you even been told that you have / had high blood cholesterol? YES NO
 ♦ Please Describe _____

II. Allergies:

- Have You Ever Been Diagnosed With Seasonal Allergies? YES NO
 ♦ Please Describe _____
- Are You Presently Taking/Have You Previously Taken Any Allergy Medications? YES NO
 ♦ Please Describe _____
- Are you allergic to and/or ever had an unfavorable / allergic reaction to any medications? YES NO
 ♦ Please Describe _____
- Are you allergic to and/or ever had an unfavorable / allergic reaction to any food items? YES NO
 ♦ Please Describe _____
- Are you allergic to and/or ever had an unfavorable / allergic reaction to bee stings, insect bites, etc.? YES NO
 ♦ Please Describe _____

III. Asthma:

- Have You Ever Been Diagnosed With Asthma and/or Exercised Induced Asthma? YES NO
- ◆ Date(s)? _____
 - ◆ Please Describe _____
- Are You Presently Taking / Have You Previously Taken Any Asthma Medications / Use an Inhaler? YES NO
- ◆ Date(s)? _____
 - ◆ Please Describe _____
- How Many Times Do You Use Your Rescue Inhaler (e.g. Albuterol, Proventil, etc.) During an Average Week? _____
- How Many Acute Asthma Attacks Have You Had In The Past 12 Months? _____
- ◆ Date(s)? _____
 - ◆ Please Describe _____
- Have You Ever Been Hospitalized As a Result of Asthma and/or Exercised Induced Asthma? YES NO
- ◆ Date(s)? _____
 - ◆ Please Describe _____
- Have You Ever Been Advised Not To Participate In Athletic Activities Due To Asthma Or Any Related Condition? YES NO
- ◆ Please Describe _____

IV. Head Injuries / Concussion:

- Have You Ever Suffered a Head Injury / Concussion (no matter how minor)? YES NO
- ◆ If yes, How many? _____
- Have You Ever Been Evaluated By a Doctor for a Head Injury / Concussion? YES NO
- ◆ Please Describe _____
- Were Any Diagnostic Tests Performed? YES NO (check all that apply)
- X-ray MRI CT-Scan Neuropsychological Testing Other _____
- Have You Ever Been Hospitalized, Knocked Out, Become Unconscious, and/or Lost Your Memory Due To A Head Injury / Concussion?
 YES NO
- ◆ Please Describe _____
- Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Head Injury / Concussion? YES NO
- ◆ Please Describe _____
- Do You Suffer From Headaches? YES NO
- ◆ When? Every Day 1-2 Times/Week 1-2 Times/Month
 - ◆ Where Are Your Headaches Located? Left Side of Head Right Side of Head
 Front of Head Back of Head All Over Your Head
- Do You Have A History of Migraine Headaches? YES NO
- ◆ How Often _____ Please Describe _____
 - ◆ Medications Taken for Migraines? _____
- Have You Had Headaches For More Than Three (3) Months? YES NO
- ◆ If yes, please explain _____

V. Eye:

When Was Your Last Eye Exam? _____

- ◆ Findings? _____

Have You Ever Suffered An Injury To Your Eye(s) and/or Been Advised That You Have An Eye Disease? YES NO

- ◆ List Date(s) / Time (e.g. practices or games) Missed _____

- ◆ Please Describe _____

Were Any Diagnostic Tests Performed? YES NO (check all that apply)
 X-ray MRI CT-Scan Other _____
Have You Ever Been Hospitalized and/or Seen An Ophthalmologist For An Eye Injury? YES NO

- ◆ Please Describe _____

Have You Ever Been Advised Not To Participate In Athletic Activities Due To An Eye Injury? YES NO

- ◆ Please Describe _____

Do you routinely suffer from blurred vision, double vision, tunnel vision, and/or any other abnormal sight? YES NO

- ◆ Please Describe _____

Do you routinely wear glasses? YES NODo you routinely wear contact lenses? YES NO Type _____Do you require any special devices / equipment? YES NO Type _____**VI. Ear / Nose / Throat:**Have You Ever Suffered An Injury To Your Ear(s), Nose, and/or Throat? YES NO

- ◆ List Date(s) / Time (e.g. practices or games) Missed _____

- ◆ Please Describe _____

Were Any Diagnostic Tests Performed? YES NO (check all that apply)
 X-ray MRI CT-Scan Other _____
Have You Ever Been Hospitalized For A Ear, Nose, and/or Throat Injury? YES NO

- ◆ Please Describe _____

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Ear, Nose, and/or Throat Injury? YES NO

- ◆ Please Describe _____

VII. Dental:

When Was Your Last Dental Exam? _____

- ◆ Findings? _____

Have You Ever Suffered An Injury To Your Mouth, Jaw, and/or Teeth? YES NO

- ◆ List Date(s) / Time (e.g. practices or games) Missed _____

- ◆ Please Describe _____

Were Any Diagnostic Tests Performed? YES NO (check all that apply)
 X-ray MRI CT-Scan Other _____
Have You Ever Been Hospitalized For A Mouth, Jaw, and/or Tooth Injury? YES NO

- ◆ Please Describe _____

VIII. Cervical Spine / Neck:

Have You Ever Suffered An Injury To Your Cervical Spine and/or Neck? YES NO

◆ List Date(s) / Time (e.g. practices or games) Missed _____

◆ Please Describe _____

Were Any Diagnostic Tests Performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan

Have You Ever Been Hospitalized For A Cervical Spine / Neck Injury? YES NO

◆ When? _____ Where? _____

◆ Please Describe _____

Have You Ever Had "Burners", "Stingers", or Brachial Plexus Injuries? YES NO

◆ How Many? _____ Date(s)/Time Missed? _____

Have You Ever Experienced Numbness and/or Tingling in Your Arms/Fingers? YES NO

◆ Date(s)? _____

◆ Please Describe? _____

Have You Ever Had Surgery of Any Kind on Your Cervical Spine / Neck? YES NO

◆ When? _____ Surgeon? _____

◆ Please Describe _____

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Cervical Spine / Neck Injury? YES NO

◆ Please Describe _____

Do You Presently Wear A Neck Roll / Collar, "Cowboy Collar" or Helmet Restrictor Plate? YES NO

Have You Ever Worn or Been Advised To Wear a Neck Roll, Neck Collar, "Cowboy Collar", and/or Helmet Restrictor Plate?

YES NO If yes, please explain _____

IX. Shoulder / Upper Arm:

Have You Ever Suffered An Injury To Your Shoulder / Upper Arm? YES NO

◆ List Date(s) / Time (e.g. practices or games) Missed _____

◆ Please Describe _____

Were Any Diagnostic Tests Performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan

Have You Ever Been Hospitalized For A Shoulder / Upper Arm Injury? YES NO

◆ When? _____ Where? _____

◆ Please Describe _____

Have You Ever Had Surgery of Any Kind on Your Shoulder / Upper Arm? YES NO

◆ When? _____ Surgeon? _____

◆ Please Describe _____

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Shoulder / Upper Arm Injury? YES NO

◆ Please Describe _____

X. Elbow / Forearm:

Have You Ever Suffered An Injury To Your Elbow / Forearm? YES NO

◆ List Date(s) / Time (e.g. practices or games) Missed _____

◆ Please Describe _____

Were Any Diagnostic Tests Performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan

Have You Ever Been Hospitalized For An Elbow / Forearm Injury? YES NO

◆ When? _____ Where? _____

◆ Please Describe _____

Have You Ever Had Surgery of Any Kind on Your Elbow / Forearm? YES NO

◆ When? _____ Surgeon? _____

◆ Please Describe _____

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Elbow / Forearm Injury? YES NO

◆ Please Describe _____

XI. Wrist, Hand, & Fingers:

Have You Ever Suffered An Injury To Your Wrist(s), Hand(s), and/or Finger(s)? YES NO

◆ List Date(s) / Time (e.g. practices or games) Missed _____

◆ Please Describe _____

Were Any Diagnostic Tests Performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan

Have You Ever Been Hospitalized For A Wrist, Hand, and/or Finger Injury? YES NO

◆ When? _____ Where? _____

◆ Please Describe _____

Have You Ever Had Surgery of Any Kind on Your Wrist, Hand, and/or Finger(s)? YES NO

◆ When? _____ Surgeon? _____

◆ Please Describe _____

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Wrist, Hand, and/or Finger Injury? YES NO

◆ Please Describe _____

XII. Spine / Low Back / Sacroiliac Joint:

Have You Ever Suffered An Injury To Your Spine / Low Back / Sacroiliac Joint? YES NO

◆ List Date(s) / Time (e.g. practices or games) Missed _____

◆ Please Describe _____

Were Any Diagnostic Tests Performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan

Have You Ever Been Hospitalized For A Spine / Low Back / Sacroiliac Joint Injury? YES NO

◆ When? _____ Where? _____

◆ Please Describe _____

Have You Ever Had Surgery of Any Kind on Your Spine / Low Back / Sacroiliac Joint? YES NO

◆ When? _____ Surgeon? _____

◆ Please Describe _____

Have You Ever Had Numbness/Tingling Down One (1) or Both Legs? YES NO

◆ Date(s)/Time Missed? _____

◆ Please Describe? _____

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Spine, Low Back, or SI Joint Injury? YES NO

◆ Please Describe _____

XIII. Hip / Groin:

Have You Ever Suffered An Injury To Your Hip / Groin (*including hernias and/or sports hernias*)? YES NO

◆ List Date(s) / Time (e.g. practices or games) Missed _____

◆ Please Describe _____

Were Any Diagnostic Tests Performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan

Have You Ever Had Surgery For A Hip / Groin Injury? YES NO

◆ When? _____ Where? _____

◆ Please Describe _____

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Hip and/or Groin Injury? YES NO

◆ Please Describe _____

XIV. Thigh / Hamstring / Quadriceps:

Have You Ever Suffered An Injury To Your Thigh, Hamstring, and/or Quadriceps? YES NO

◆ List Date(s) / Time (e.g. practices or games) Missed _____

◆ Please Describe _____

Were Any Diagnostic Tests Performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan

Have You Ever Been Hospitalized For A Thigh, Hamstring, and/or Quadriceps Injury? YES NO

◆ When? _____ Where? _____

◆ Please Describe _____

Have You Ever Had Surgery For A Thigh, Hamstring, and/or Quadriceps Injury? YES NO

◆ When? _____ Surgeon? _____

◆ Please Describe _____

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Thigh, Hamstring, or Quadriceps Injury? YES NO

◆ Please Describe _____

XV. Knee / Patella:

Have You Ever Suffered An Injury To Your Knee and/or Patella (kneecap)? YES NO

◆ List Date(s) / Time (e.g. practices or games) Missed _____

◆ Please Describe _____

Were Any Diagnostic Tests Performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan

Have You Ever Been Hospitalized For A Knee and/or Patella Injury? YES NO

◆ When? _____ Where? _____

◆ Please Describe _____

Have You Ever Had Surgery For A Knee and/or Patella Injury? YES NO

◆ When? _____ Surgeon? _____

◆ Please Describe _____

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Knee / Patella Injury? YES NO

◆ Please Describe _____

Have You Ever/Do You Presently Wear A Knee Brace? YES NO

◆ Which Knee? _____ Brand / Model of Brace? _____

◆ Reason for Wearing ? _____

XVI. Ankle / Lower Leg:

Have You Ever Suffered An Injury To Your Ankle / Lower Leg? YES NO

◆ List Date(s) / Time (e.g. practices or games) Missed _____

◆ Please Describe _____

Were Any Diagnostic Tests Performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan

Have You Ever Been Hospitalized For An Ankle / Lower Leg Injury? YES NO

◆ When? _____ Where? _____

◆ Please Describe _____

Have You Ever Had Surgery For An Ankle / Lower Leg Injury? YES NO

◆ When? _____ Surgeon? _____

◆ Please Describe _____

Have You Ever Been Advised Not To Participate In Athletic Activities Due To An Ankle / Lower Leg Injury? YES NO

◆ Please Describe _____

Do You Presently Tape Your Ankle(s) Use Ankle Brace(s) Other

◆ Please Describe _____

XII. Foot / Toes:

Have You Ever Suffered An Injury To Your Foot / Toe(s)? YES NO

◆ List Date(s) / Time (e.g. practices or games) Missed _____

◆ Please Describe _____

Were Any Diagnostic Tests Performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan

Have You Ever Had Surgery For A Foot / Toe Injury? YES NO

◆ When? _____ Surgeon? _____

◆ Please Describe _____

Have You Ever Been Advised Not To Participate In Athletic Activities Due To An Foot and/or Toe Injury? YES NO

◆ Please Describe _____

XIII. Ribs / Thorax / Chest:

Have You Ever Suffered An Injury To Your Rib / Thorax / Chest? YES NO

◆ List Date(s) / Time (e.g. practices or games) Missed _____

◆ Please Describe _____

Were Any Diagnostic Tests Performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan

Have You Ever Had Surgery For A Rib / Thorax / Chest Injury? YES NO

◆ When? _____ Where? _____

◆ Please Describe _____

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Ribs, Thorax, and/or Chest Injury? YES NO

◆ Please Describe _____

XIX. Abdomen:

Have You Ever Been Diagnosed With A Problem With Your Stomach, Abdomen, Intestines, or Rectum? YES NO

◆ List Date(s) / Time (e.g. practices or games) Missed _____

◆ Please Describe _____

Have You Ever Suffered An Injury To Your Abdomen? YES NO

◆ List Date(s) / Time (e.g. practices or games) Missed _____

◆ Please Describe _____

Were Any Diagnostic Tests Performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan

Have You Ever Had Surgery For An Abdomen Injury? YES NO

◆ When? _____ Where? _____

◆ Please Describe _____

Do You Routinely Suffer From Severe Or Recurrent Abdominal Pain? YES NO

◆ Please Describe _____

Do you Routinely Suffer From Chronic or Recurrent Diarrhea? YES NO

◆ Please Describe _____

Do You Have Only One Of Two Paired, Functioning Organs (e.g. kidney, testicles, ovary, etc.)? YES NO

◆ Please Describe _____

Have You Ever Been Advised Not To Participate In Athletic Activities Due To An Abdomen Injury? YES NO

◆ Please Describe _____

XX. Medical Testing:

Have You Ever Been Diagnosed With A Communicable Disease (e.g. STD, HIV, Hepatitis A, B, or C, Herpes Simplex, Syphilis, Tuberculosis)?

YES NO

◆ List Dates/Time Missed _____

◆ Please Describe _____

XXI. Dermatological:

Do you have any skin problems that we should be aware of (e.g. itching, rashes, acne, warts, eczema, fungus, etc.)? YES NO

◆ Please Describe _____

Have you ever been under the care of a dermatologist for any condition? YES NO

◆ Please Describe _____

Have you ever been advised not to participate in athletic activities due to a skin condition? YES NO

◆ Please Describe _____

XXII. Prescription Medications:

Please List **ALL** Prescription & Over-the-Counter Medications That You Are **CURRENTLY** Taking or **Have Taken** In The PAST Two (2) Years, & For What Purpose:

<u>MEDICATION</u>	<u>PURPOSE</u>	<u>DOSAGE</u>	<u>DATE(S)</u>

XXIII. Supplements / Ergogenic Aids:

Please List **ALL** Supplements / Ergogenic Aids That You Are **CURRENTLY** Taking or **Have Taken** In The PAST Two (2) Years, & For What Purpose:

<u>SUPPLEMENT</u>	<u>PURPOSE</u>	<u>DOSAGE</u>	<u>DATE(S)</u>

XXIV. Heat Related Problems:

Have You Ever Suffered From A Heat Related Injury? YES NO (check all that apply):

- ◆ Heat Cramps- Date(s)? _____
- ◆ Heat Syncope (Fainting)- Date(s)? _____
- ◆ Heat Exhaustion- Date(s)? _____
- ◆ Heat Stroke- Date(s)? _____

Have You Ever Received Intravenous Fluids (IV) For A Heat Related Problem? YES NO

◆ Date(s)? _____

Have You Ever Been Hospitalized For a Heat-Related Problem? YES NO

◆ Date(s)? _____ Where? _____

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Heat Related Injury? YES NO

◆ Please Describe _____

XXV. Diabetic History:

Have You Ever Been Diagnosed With Diabetes? YES NO

◆ Date? _____

Are You Presently Taking or Have You Taken Any Diabetic Medications? YES NO

<u>Medication</u>	<u>Form</u>	<u>Dosage</u>	<u>Frequency</u>

Do You Daily Monitor Your Blood Sugar Level? YES NO

◆ How Many Times Per Day? _____ What Is Your Average Level? _____

Have You Had Your A1C Level Checked Within The Last Three (3) Months? YES NO Level _____

Have You Had Any Hypoglycemic Episodes (low blood sugar) Within The Last Twelve (12) Months? YES NO

◆ Please Describe _____

Have You Ever Been Advised Not To Participate In Athletic Activities Due To Diabetes? YES NO

◆ Please Describe _____

Please List Any Precautions That You Take and/or Additional Information Not Mentioned Above:

XXVI. Sickle Cell Anemia:

Have you ever been tested for Sickle Cell Anemia that you are aware of? YES NO

◆ Date? _____ Result? _____

Does any member of your family carry the Sickle Cell Trait / have Sickle Cell Anemia that you are aware of? YES NO

◆ Please Describe _____

Have you ever been advised that you carry the Sickle Cell Trait / have Sickle Cell Anemia? YES NO

◆ Please Describe _____

XXVII. For Females Only:

- YES NO At what age did you have your first menstrual period? _____
- YES NO Have you had menstrual periods within the past 12 months?
 - ◆ If yes, how many? _____ When was your most recent menstrual period? _____
 - ◆ How much time do you usually have from the start of one period to the start of another? _____
 - ◆ What was the longest time between menstrual periods within the past year? _____
- YES NO Do you have painful or heavy menstrual periods?
- YES NO Do you take any medications during your menstrual periods? If yes, what? _____
- YES NO Do you take birth control pills? If yes, what brand? _____
- YES NO Have you ever had any problems with your breasts?
- YES NO Have you had a pelvic examination within the last year?

XXVIII. Please Answer: {All questions are strictly **CONFIDENTIAL** & will not be shared with parents or coaches!}

- YES NO Have you ever had any injury or illness other than those already noted?
- YES NO Do you have any ongoing or chronic illnesses?
- YES NO Have you ever been hospitalized overnight?
- YES NO Have you ever been told by a physician to restrict your sports activity or not to participate in a sport?
- YES NO Are you currently under a physician's care for any medical conditions?
- YES NO Have you ever been under the care of a psychiatrist and/or psychologist?
- YES NO Have you consulted and/or been under the care of a chiropractor, hypnotist, acupuncturist, massage therapist, spiritual healer, and/or other such practitioner in the past five (5) years?
- YES NO Have you ever had a rash or hives develop during and/or after exercise?
- YES NO Do you cough, wheeze, or have trouble breathing during or after exercise / practice?
- YES NO Have you ever been told that you have kidney disease?
- YES NO Have you ever had rubella ("German Measles") and/or Rubeola ("red measles")?
- YES NO Have you ever had a stomach and/or duodenal ulcer?
- YES NO Have you had a viral infection (i.e. mononucleosis, myocarditis, etc.) within the past six (6) months?
- YES NO Have you ever had seizures, convulsions, and/or epilepsy?
- YES NO Have you ever had gall bladder disease and/or a urinary problem?
- YES NO Do you have ringing in your ears or trouble hearing?
- YES NO Do you have frequent ear infections or nosebleeds?
- YES NO Have you ever had an abnormal chest x-ray and/or pneumonia?
- YES NO Do you require any special equipment (braces, neck rolls, dental, orthotics, hearing aids, etc.)
- YES NO Have you ever had the chickenpox? If yes, when? _____

- YES NO Are you aware of any reasons why you should not participate in intercollegiate athletics at the Southwestern Oklahoma State University at this time?
- YES NO Have you had a tetanus booster within the past five (5) years? If yes, when? _____
- YES NO Have you ever received the Hepatitis B (HBV) Vaccination series (all 3 shots)? If yes, when? _____
- YES NO Do you smoke cigarettes, use smokeless tobacco, or use tobacco in any form?
- YES NO Do you use alcohol? If yes, how often? _____
- YES NO Have you ever used / tried marijuana, cocaine, or any other illicit "street" drugs?
- YES NO Do you have any questions regarding drugs, tobacco, or alcohol?
- YES NO Do you feel stressed out? If yes, do you feel as though you get the necessary support to deal with your stress?
- YES NO Have you had a weight change (loss or gain) of greater than 10 pounds in the past year?
- YES NO Are you a vegetarian? If yes, what type? _____
- YES NO Do you regularly lose weight to participate in your sport?
- YES NO Do you want to weigh more or less than you presently do?
- YES NO Have you ever felt forced to limit your food intake due to concerns about your weight and/or body size?
- YES NO Have you had a history of anorexia, bulimia (forced vomiting), and/or any other eating disorders?
- YES NO Would you like to meet with a dietitian to discuss your nutritional needs or eating habits?

If you have answered **YES** to any of the above, please explain: _____

Please describe below any further injury information, which is knowledgeable to you and not required on this form.

I, the undersigned, hereby acknowledge, affirm, and represent that all statements on pages one (1) through fourteen (14) are true and accurate to the best of my knowledge; and that no answers or information have been withheld. If any information and/or statements are false and/or have been omitted in reference to my past and/or present medical history, I understand and acknowledge that my health and physical welfare may be jeopardized as a result and that I may suffer physical harm.

Student-Athlete Signature

Date

Student-Athlete Print Name

Parent/Guardian Signature *(if under 18 years of age)*

Date

Parent/Guardian Print Name

Witness

Date

Reviewed By:

Reviewer's Signature

Date

Reviewer Print Name