UNIVERSITY OF THE DISTRICT OF COLUMBIA

I. Cardiovascular Risk Factors:

Have you ever had **chest pain, dizziness, fainting and/or shortness of breath** during or after 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 or 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 _____

Do you or anyone in your family have a history of **high blood pressure**? YES NO

Please Describe _____

Do you or anyone in your family have a history of **high blood cholesterol**? YES NO

♦ Please Describe _____

II. Allergies:

Have You Ever Been Diagnosed with ANY Allergies or had any unfavorable reactions to foods, insects and/or drugs? YES NO

♦ Please Describe_____

Are You Presently Taking/Have You Previously Taken Any Allergy Medications? YES NO

♦ Please Describe_____

III. Asthma:

Have You Ever Been Diagnosed With *Asthma and/or Exercised Induced Asthma*? YES NO

♦ Please Describe (include dates and details): _____

Are You Presently Taking / Have You Previously Taken *Any Asthma Medications / Use an Inhaler*? YES NO

♦ Date(s)? Type of Medication: _____

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

♦ Please Describe (include dates and details): _____

Have You Ever Been Evaluated By a Doctor for a Head Injury / Concussion? YES NO

♦ Please Describe _____

Were Any Diagnostic Tests Performed? YES NO If yes, please list:_____

Have You Ever Been *Hospitalized, Knocked Out, and/or Suffered Memory Loss to A Head Injury / Concussion*? YES NO

♦ Please Describe (include dates and details): _____

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

♦ Please Describe _____

Student-Athlete's Name _____

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 _____
- Do you routinely wear glasses and/or contact lenses? YES NO

VI. Ear / Nose / Throat:

Have You Ever Suffered An Injury To Your *Ear(s), Nose, and/or Throat*? YES NO

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

Were Any Diagnostic Tests Performed? YES NO If yes, please list: _____

Have You Ever Been Hospitalized For An Ear, Nose, and/or Throat Injury? YES NO

Have You Ever Been Advised Not To Participate In Athletic Activities Due To An 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

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

VIII. Cervical Spine / Neck:

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

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

Were Any Diagnostic Tests Performed? If yes, please list with findings: _____

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

- Please Describe (include location and date): _____

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

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

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

- Please Describe _____

IX. Shoulder / Arm / Elbow / Wrist / Hand:

Have You Ever Suffered An Injury To Your *Shoulder / Arm / Elbow / Wrist / Hand*? YES NO

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

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

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

- Please Describe (include dates and details): _____

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

- Please Describe _____

Student-Athlete's Name _____

X. Spine / Low Back / Sacroiliac Joint:

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

♦ Please Describe (include dates and details): _____

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

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

♦ Please Describe (include dates and details): _____

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 _____

XI. Hip / Groin:

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

♦ List Please Describe (include dates and details): _____

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

♦ Please Describe (include dates and details): _____

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

♦ Please Describe _____

XII. Thigh / Hamstring / Quadriceps:

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

♦ Please Describe (include dates and details): _____

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

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

♦ Please Describe _____

XIII. Knee / Patella:

Have You Ever Suffered an Injury to Your *Knee and/or Patella (kneecap)*? YES NO

♦ Please Describe (include dates and details): _____

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

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

♦ Please Describe (include dates and details): _____

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

♦ Please Describe _____

XIV. Ankle / Lower Leg / Foot:

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

♦ Please Describe (include dates and details): _____

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

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

♦ Please Describe (include dates and details): _____

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

Student-Athlete's Name _____

XV. Abdomen / Ribs / Thorax / Chest:

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

- Please Describe (include dates and details): _____

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

- Please Describe (include dates and details): _____

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

- Please Describe _____

XVI. 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

- Please Describe _____

XVII. Dermatological (Skin):

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

- Please Describe _____

Have you ever been diagnosed with a staph infection and/or MRSA infection on any part of your body? YES NO

- Please Describe _____

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

XVIII. 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:

MEDICATION	PURPOSE	DOSAGE	DATE(S)

XIX. Supplements / Ergogenic Aids:

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

SUPPLEMENT	PURPOSE	DOSAGE	DATE(S)

Student-Athlete's Name _____

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XX. 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 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 _____

XXI. 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

Medication	Form	Dosage	Frequency

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

_____

XXII. Sickle Cell Anemia:

Have you ever been tested for Sickle Cell Anemia that you are aware of? YES NO DON'T KNOW

- Date? _____ Result? _____

The NCAA recommends that all student athletes be aware of their sickle cell status. If you checked "don't know" above, please review the attached Sickle Cell Information Sheet / Waiver, and either arrange for sickle trait testing or complete the testing waiver.

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

- Please Describe _____

XXIII. Females Only:

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? _____

YES NO Do you take birth control pills? Brand:_____

YES NO Do you take any medications during your menstrual periods? If yes, what? _____

Student-Athlete's Name _____

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XXIV. Please Answer: ***Please use space provided to describe in detail. You may use the back of this sheet.***

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? (Circle all that apply.)

YES NO Have you ever had a rash or hives develop during and/or after exercise? _____

YES NO Do you cough, wheeze, have chest tightness, have shortness of breath, or have trouble breathing during or after exercise / practice, at night, or after exposure to allergens / pollutants? _____

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 Do you have ringing in your ears or trouble hearing? _____

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 Georgetown 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 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 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? _____

CONSENT FOR TREATMENT & RELEASE OF MEDICAL INFORMATION

I hereby authorize the members of the University of the District of Columbia sports medicine department, its physicians and designees to treat any injury or illness that affects my ability to participate in athletic activities at University of the District of Columbia. I consent to the release of my medical records and related information to University of the District of Columbia personnel for use in connection with diagnosis, treatment, and/or rehabilitation of such injuries or illness and for determinations of fitness to return to play. This authorization shall expire at the end of the current academic year and/or the end of competitive season, whichever should come later in time.

_____ _____

Student-Athlete Signature (Print Name) Date

_____ _____

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

_____ _____

Witness Signature Print Name) Date

I verify that all the information is accurate and complete. I understand that failure to disclose previous medical conditions may result in a medical disqualification. I understand that University of the District of Columbia is not responsible for expenses related to any previously existing conditions.

Signature of Athlete: _____ Date: _____

Signature of parent/guardian: _____ Date: _____