

## Tufts University Athletic Pre-Participation Health Questionnaire For Returning Athletes

SPORT \_\_\_\_\_ DATE: \_\_\_\_\_

Last Name	First Name	ID#	Class Year
Cell Phone #	Address		
E-mail Address			

### SINCE YOU WERE LAST CLEARED FOR YOUR SPORT!! (ie in Past 12 Months) Briefly explain "Yes" answers below each question

1. Has a doctor ever denied or restricted your participation in sports? YES NO
2. Are you currently under treatment for an illness? YES NO
3. Are you currently taking medication? If yes, please list. YES NO
4. Have any close members of your family (parents, aunts, uncles, siblings) under 50 years of age died suddenly of a heart problem YES NO
5. Do you have any known allergy? If yes, please list. YES NO  
(include allergy to: food, medications, animals, insects, environment, etc)
6. Have you been hospitalized during the **past 12 months**? YES NO
7. Do you have asthma? YES NO
8. Do you have Diabetes? YES NO
9. Have you been told you had High Blood Pressure? YES NO
10. Have you been told you had a heart problem or heart disease? YES NO
11. Have you passed out or nearly passed out with exercise? YES NO
12. Have you experienced a racing heart, palpitations or skipped heart beat that feel abnormal? YES NO
13. Do you have Long QT Syndrome? YES NO
14. Do you or a family member have Marfan Syndrome? YES NO
15. Have you experienced **severe** pain in your chest during exercise? YES NO
16. Were you born without or are you missing a kidney, eye, or testicle? YES NO
17. Have you had Mono within the past 6 weeks? YES NO
18. Have you had a serious head injury or concussion? YES NO
19. Do you have a seizure disorder? YES NO

**Complete Other Side**

20. Have you had a skin infection such as Staph or Herpes? YES NO
21. Have you been diagnosed with an Eating Disorder? YES NO
22. Do you diet constantly and find you are preoccupied with thoughts of food? YES NO
23. Do you feel the need to purge through vomiting, laxatives, diet pills or excessive exercise? YES NO
24. For Women: When was your last menstrual period? \_\_\_\_\_  
 How many periods have had in the last 12 months? \_\_\_\_\_
25. Would you like help with any eating or nutritional concerns? YES NO
26. Do you smoke cigarettes? If yes, how much? YES NO
27. Have you had any surgery in the **past 12 months**? YES NO  
 Type of surgery:  
 Date of surgery:
28. Have you had any injuries in the **past 12 months**? YES NO  
 List type of injury and date of occurrence
29. Is there any other problem or concern that we should be aware of? YES NO

**I certify that I have answered the above questions truthfully and to the best of my knowledge and fully understand that approval for participation in my designated sport is based in large part upon the above information**

\_\_\_\_\_  
 Student Signature Date

*If you develop any medical or orthopedic problems between now and the start of your season it is essential that you notify the sports medicine staff.*

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**Authorization for release of confidential information:**

*By signing this authorization form, I hereby consent to the release of information both to and from the health Center Staff and the Sports Medicine Staff and to and from the coaching Staff of my sport in so far as the release of this information is pertinent to my participation in my chosen sport(s). the information will not be released to other parties without my permission. I understand that I may revoke this release at any time.*

\_\_\_\_\_  
 Student Signature Date

Reviewed (Sports Medicine): \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed (Health Service): \_\_\_\_\_ Date: \_\_\_\_\_