University of California Santa Barbara Student Health Service

PREPARTICIPATION ATHLETIC CLEARANCE INITIAL HISTORY (1st of 2 PAGES)

Explain "yes" answers below. Circle questions if you don't know the answers.

	Yes	No		Yes	No
1. Has a doctor ever denied or restricted your sports participation for any reason?			LUNG QUESTIONS		
2. Do you have an ongoing medical condition (like diabetes or asthma)?			18. Has a doctor ever told you that you have asthma or allergies?		
3. Have you ever been hospitalized or had a serious illness?			19. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
4. Were you born without or are you missing a kidney, spleen, testicle, or any other organ?			27. Have you ever used an inhaler or taken asthma medicines?		
5. Are you currently taking any prescription or nonprescription (over-the-counter) medicines, including birth control pills?			SKIN QUESTIONS		
6. Do you take any vitamins or supplements?			28. Have you had any rashes or other skin problems?		
7. Do you have allergies to medicines, pollens, foods or stinging insects?			29. Have you had skin infections such as herpes, impetigo, or Staph (MRSA)?		
HEART QUESTIONS			NEUROLOGY QUESTIONS		
8. Have you ever passed out or nearly passed out DURING exercise?			30. Have you ever had a head injury or concussion?		
9. Have you ever passed out or nearly passed out AFTER exercise?			31. Have you ever been hit in the head and been confused or lost your memory?		
10. Have you ever had discomfort, pain, or pressure in your chest during exercise?			32. Have you ever had a seizure?		
11. Does your heart race or skip beats during exercise?			33. Do you have headaches with exercise?		
12. Has a doctor ever told you that you have (check all that apply): □ High blood pressure □ Heart mumur □ High cholesterol □ Heart infection			34. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
13. Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram)			35. Have you ever been unable to move your arms or legs after being hit or falling?		
FAMILY QUESTIONS			36. When exercising in the heat, do you have severe muscle cramps or become ill?		
14. Has any family member or relative died of heart problems or of sudden death before age 50?			VISION QUESTIONS		
15. Does anyone in your family have asthma?			37. Have you had any problems with your eyes or vision?		
16. Does anyone in your family have a significant illness such as heart problems, diabetes, etc.?			38. Do you wear glasses or contact lenses?		
17. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?			39. Do you have any concerns that you would like to discuss with a doctor?		

Explain "YES" answers here:

_____

_____

_____

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

_____

PRINT NAME SIGNATURE PERM # DATE

PREPARTICIPATION ATHLETIC CLEARANCE INITIAL HISTORY (2nd of 2 PAGES)

Explain "yes" answers below. Circle questions if you don't know the answers.

	Yes	No
SUBSTANCE USE		
20. In an average week do you typically have 10 or more alcoholic drinks?		
21. Have you ever passed out or had memory blanks as a result of drinking?		
22. Have you ever felt like you ought to cut down on your drinking?		
23. Have you ever been injured as a result of drinking?		
MENTAL HEALTH QUESTIONS		
24. Have you ever been severely depressed?		
25. Are you taking or have you ever taken medications for depression or other mental health problems?		
26. Have you ever received medical care or been hospitalized for mental health problems or an eating disorder?		
WEIGHT QUESTIONS		
27. Are you trying to gain or lose weight?		
28. Has anyone recommended you change your weight or eating habits?		
29. Do you limit or carefully control what you eat?		
FEMALES ONLY		
30. How old were you when you had your first menstrual period?_____		
31. Have you ever missed a menstrual period?		
32. How many periods have you had in the last 12 months?_____		

ORTHOPEDIC QUESTIONS	Yes	No
33. Have you ever had a stress fracture?		
34. Have you been told that you have or have you had an X-ray for neck instability?		
35. Do you regularly use a brace or assistive device?		
36. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis that caused you to miss a practice or game?		
37. Have you had any broken or fractured bones or dislocated joints?		
38. Have you had a bone or joint injury that required X-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, cast or crutches?		

CIRCLE any injured area below:

Head	Neck	Upper Back	Shoulder R L	Upper Arm R L	Elbow R L	Forearm R L	Hand/Fingers R L
Chest	Lower Back	Hip R L	Thigh R L	Knee R L	Calf/Shin R L	Ankle R L	Foot/Toes R L

Explain "YES" answers here:

_____

_____

_____

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

_____

PRINT NAME SIGNATURE PERM # DATE

Patient Label: Page:_____

UCSB Recreational Sports

SPORTS PARTICIPATION CLEARANCE FORM

By signing this Sports Participation Clearance Form, I acknowledge that I have performed a physical examination on the following patient:

_____

(Please print patient's name)

I acknowledge also that I have found this patient fit for participation in the following sport(s):

_____

(Please print name(s) of sport(s))

Signed: _____ Date _____

(Clinician signature)

Clinician name: _____ Phone: (___)_____

Please note: *The actual physical examination form should be filed with the patient's records at the clinic where the physical exam was performed.*

This form may be faxed to UCSB Recreational Sports at: (805) 893-5973

J\FORMS\ATHLETICS\SPORTS CLEARANCE 2/12/02