Pre-Participation

MEDICAL HISTORY FORM
World University Games

Return to: register@usateam.org Date of Completion_____

Name _____ Date of birth _____

Sex _____ Age _____ Height _____ Weight _____ Sport _____

Personal medical insurance that covers you at the event is required. The local organizing committee will cover first response to injury, accident, or sickness, but ongoing coverage by your personal insurance is required.

. Medical Insurance Company _____. Policy Number _____ .

Medicines: include over the counter and supplements	**Allergies or Sensitivities:**

Explain "Yes" answers below. **Highlight** questions you don't know the answers to.

GENERAL QUESTIONS	Y	N
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐Anemia ☐Diabetes ☐Infections ☐ Seizures		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Y**	**N**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats during exercise?		
8. Has a doctor ever said that you have any of these heart problems? ☐High blood pressure ☐heart murmur ☐High cholesterol ☐ heart infection ☐ Other: _____		
9. Have you ever had a test for your heart? (ECG, echocardiogram) When? Why?		
10. Do you get lightheaded or more short of breath than expected during exercise?		
11. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Y**	**N**
12. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50?		
13. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
14. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Y**	**N**
15. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
16. Have you ever had broken/fractured bones, stress fractures, or dislocated joints?		
17. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
18. Do you regularly use a brace, orthotics, or other assistive device?		
19. Do any of your joints become painful, swollen, warm, or red?		
20. Do you have a bone, muscle, or joint injury that bothers you?		

MEDICAL QUESTIONS	Y	N
21. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
22. Have you ever been told you have asthma or used an inhaler or taken asthma medicine?		
23. Do you have sickle cell trait or disease?		
24. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
25. Do you have a pain, bulge or hernia in the groin area?		
26. Have you had infectious mononucleosis (mono) within the last 2 months?		
27. Do you have any rashes, pressure sores, or other skin problems?		
28. Have you had a herpes or MRSA skin infection?		
29. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
30. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
31. Do you have headaches with exercise?		
32. Have you ever become ill while exercising in the heat?		
33. Do you get frequent muscle cramps when exercising?		
34. Do you wear glasses or contact lenses?		
35. Have you had any problems with your eyes or vision? Any eye injuries?		
36. Do you worry about your weight?		
37. Are you trying to or has anyone recommended that you gain or lose weight?		
38. Are you on a special diet or do you avoid certain foods		
39. Have you ever had an eating disorder?		
40. Do you have any concerns that you would like to discuss with a doctor?		.
FEMALES ONLY	**Y**	**N**
41.Age when you had your first menstrual period?		
42. Heavy or painful menses?		
43. How many periods have you had in the last 12 months?		

Explanation (you can enter multiple number on a line if more than one health issue caused by same event):

_____ _____

#_____ _____

#_____ _____

#_____ _____

#_____ _____