RETURNING ATHLETE HEALTH STATUS QUESTIONNAIRE

Name_____Date of Birth_____

Sport_____ Student ID_____Eligibility Remaining_____yrs

SINCE THE END OF YOUR LAST SEASON… (Please circle yes or no, and answer any related questions)

1. Have you had a concussion? (If yes, how many? When?_____) YES NO
2. Have you taken any prescription medications? (If yes, please list_____) YES NO
3. Have you taken any non-prescription medications? (I.e., aspirin, vitamins, ibuprofen_____) YES NO
4. Have you fainted, got knocked out or otherwise lost consciousness? (If yes, circle which) YES NO
5. Have you had problems with frequent headaches? YES NO
6. Have you had problems with concentration, mood changes or depression? (circle which) YES NO
7. Are you aware that the Campus Health Center has counseling services for the above problems? YES NO
8. Did you for the first time get contacts or glasses or have eyesight problems? YES NO
9. Have you had any problems with your hearing? YES NO
10. Have you had any problems with your teeth, tonsils or mouth? YES NO
11. Have you had any problems with stomach pains, constipation or diarrhea? YES NO
12. Have you had any problems with chest pains or difficulty breathing? YES NO
13. Have you had surgery? (If yes, what kind_____) YES NO
14. Have you had any problems with heat or cold exposure? YES NO
15. Did you miss any practices because an injury? YES NO
16. Did you miss any competitions because of an injury? YES NO
17. Have you had neck or back pain for more than one day? YES NO
18. Have you had any concerns about lack of balance in your diet? YES NO
19. Have you had concerns about your weight? YES NO
20. Have you contracted any sexually transmitted diseases? YES NO
21. Were you sick/ill while your sport was in-season? (If yes, how many times_____) YES NO
22. (Women only) Have you had pain in, or discharge from your breasts? YES NO
23. (Women only) Have you had problems with your bladder or urinary tract infections? YES NO
24. (Women only) How many menstrual periods did you miss in the last year? _____

SINCE THE END OF YOUR LAST SEASON have you had… (Please circle yes or no and describe as appropriate)

1. Have you tested Positive for COVID-19? If yes, please indicate positive test date YES NO

   _____

2. Any sports related injuries? If yes, please indicate. YES NO

   _____

3. Did you see a physician for the injury(ies) or for any other reason? If yes, please describe. YES NO

   _____

4. Do you have any other health concerns not mentioned above? If yes, please describe. YES NO

   _____

I have read and answered the above questions truthfully and to the best of my ability.

_____ _____

Signature Date

Height_____ Weight_____ Blood Pressure_____/_____ Pulse_____