Carleton University Ravens – Club Team or Varsity Tryout
Pre-Participation Health Questionnaire

PLAYER INFORMATION:

Team: ____

Last Name: ________________ **First Name:** ________________ **Pronouns:** ______________ **DOB**____/____/____ (DD / MM / YY)

OHIP number: ___________________________**version code (2 letters on card):**_______

Email address____ **Cell #:**_______________________

Ottawa Address ___________________________**City**_Ottawa **Province** Ontario **Postal Code**__________

Home # (___)________________ **Work # (___)**_________________**Cell # (___)**_________________

In case of emergency, contact (if different than Parent / Legal Guardian above)

Name ______________________________***Relationship*** ___________________

Phone (Home) ____________________***(Work)***____________________***(Cell)***___________________

ATHLETE MEDICAL HISTORY

Past Medical History: ____

____

Ongoing or Chronic illness: ____

Have you been diagnosed with COVID-19? Yes No If yes, date & symptoms _________________________________

Have you ever had any of the following (check all that apply):

GENERAL HISTORY	YES	NO		YES	NO
Infectious disease (Hepatitis, HIV, Mono)			Stomach ulcer/intestinal disorder/Hernia		
Diabetes			Cancer		
Asthma/Breathing Disorder			Liver or Kidney Disease		
Blood disorder/Anemia/Iron deficiency			Fungus, MRSA, skin infection		
Epilepsy/Seizure/Neurologic disorder			Brachial Plexus injury (“burner”, stinger)		
Missing kidney, eye, testicle or other organ			Injury to internal organ (Liver, spleen, kidney)		
Heat illness or exhaustion			Numbness/tingling in arms, hands, legs, feet		

CARDIORESPIRATORY HISTORY	Yes	No	Explanation
Congenital Heart Disease			
Heart Murmur			
Irregular Heart Rate/Rhythm			
High Blood Pressure or High Cholesterol			
Myocarditis/Pericarditis			
Dizziness/Fainting episode during or post exercise?			
Chest pain, tightness or palpitations related to exertion?			
Trouble breathing, fatigue, cough during/after activity?			
Have you been restricted from sport for cardiac reasons, required an ECG or echocardiogram or a consultation with a cardiologist?			

VISION / DENTAL HISTORY	Yes	No	Explanation
Do you wear glasses or contacts? During sport?			
Do you have a past history of eye injury?			
Do you wear any dental appliances (bridge, plate, false teeth, braces, dentures)?			

FAMILY HISTORY

Has any member of your immediate family (parent, sibling, grandparent) had the following:	**Yes**	**No**	**Explanation**
Sudden Death before age 50 due to cardiac causes?			
Sudden Death during sports participation?			
Heart disease in relative <50 years of age			
Hypertrophic or dilated cardiomyopathy, long QT syndrome, heart arrhythmia, Marfan Syndrome, genetic cardiac condition			

IMMUNIZATIONS

Immunization	**Date**	**Immunization**	**Date**
Tetanus/diphtheria		Measles/Mumps/Rubella	
Hepatitis B		Chickenpox/Varicella	
Meningitis/Menactra		Flu Shot/H1N1	
Gardasil/HPV		COVID-19 - *type*	

ALLERGIES:

Have you ever had an adverse reaction to anesthesia or freezing? Yes___ No___

List any allergies you have (medications, tape, insects, plants, foods) and describe what happens:

Substance____________________________________ Reaction____________________________________

Substance____________________________________ Reaction____________________________________

Substance____________________________________ Reaction____________________________________

MEDICATIONS/SUPPLEMENTS:

Are you currently taking any prescription or nonprescription (over-the-counter) medicines or any supplements/vitamins?

1.
2.
3.
4.
5.
6.

LIFESTYLE & HEALTH	**Yes**	**No**	**Explanation**
How many hours do you train for your sport per week?		Hours	
Are you satisfied with your weight?			
Do you have any dietary problems? Food Restrictions?			
Do you consume alcohol? chew or smoke tobacco?			
Have you used any rec drugs (Marijuana, Cocaine, Ecstasy) or prescription drugs for non-medical reasons?			
Have you ever tried to control your weight with fasting/vomiting/laxatives/diuretics/diet Pills?			
Have you ever struggled with an eating disorder?			
Do you have ADHD / ADD or other learning disability			
Do you feel stressed out or depressed?			

FEMALE ATHLETE REVIEW	**Answer**
How old were you when you had your first menstrual period?	
How many periods have you had in the past 12 months?	
Have you ever gone more than 3 months without having a menstrual period?	
Normal duration between periods?	(days)
How many days does your period last? Light, moderate, heavy?	
When was your last menstrual period (LMP)?	
Do you take birth control pills or hormones? If Yes please name.	
Have you ever had a Pap test? Most recent date?	
Have you ever been treated for anemia or a stress fracture?	

MENTAL HEALTH
Have you ever been diagnosed with a mental health condition (depression, anxiety, psychosis) YES NO

	Never	Sometimes	Mostly
I feel sad even after a good practice or competition			
I rarely get pleasure from competing anymore and have lost interest in my sport			
I get little or no pleasure from my athletic successes			
I am having problems with my appetite and weight			
I do not feel rested and refreshed when I wake up			
I am having problems maintaining my focus and concentration			
I feel like a failure as an athlete and person			
I cannot stop thinking about being a failure and quitting sports			
I am drinking alcohol or taking supplements to improve my mood			
I have thoughts of ending my life			

ORTHOPAEDIC HISTORY
Do you use any special protective or corrective equipment or devices for your sport or position (for example, knee brace, special neck roll, foot orthotics, core shorts, hearing aid) Yes___ No__ Explain:___________________________________
Have you ever injured any of the following (check all that apply):

	Year	Diagnosis		Year	L or R	Diagnosis
Head / Face			Clavicle/AC or SC Joint			
Neck			Shoulder			
Back			Upper arm/Elbow			
Abdomen / Pelvis			Forearm/Wrist/Hand			
Chest or Ribs			Hip/Groin			
			Thigh/Hamstring			
			Knee			
			Lower leg/Ankle/Foot			

HEAD INJURY/CONCUSSION HISTORY

Question	Yes	No	Explanation
Have you ever had a head injury or concussion?			
Do you have headaches with exercise or frequent, severe headaches?			

	Year	Sport	Loss of consciousness	Amnesia	Seen by MD?	Time off sports	Time off school	CT/MRI
1								
2								
3								
4								

MEDICAL QUESTIONNAIRE DECLARATION & CONSENT:

I certify that I have answered this questionnaire completely and correctly to the best of my knowledge. I certify that I have not had any prior illness or injuries other than those I have listed on this questionnaire. I, the undersigned, authorize the Carleton medical staff and other such medical personnel and medical institutions which may be engaged in my care in the event of illness or injury to release to my coaches, trainers and/or administration, information contained on this form or other information about my health status, as it relates to my USPORT participation.

Date_______________________ Players signature____
dd/mm/yr

Physician's signature____