Pre-Participation Health Questionnaire

University of Ottawa Gee Gees

Date:

Name: **Male** ☐ **Female** ☐ **Date of Birth**:

Email: **Sport**:

Area of Study:

Home Address:

Local Address **Family Doctor:** **Phone #** **City**:

EMERGENCY CONTACT INFORMATION

Name
Relationship to you (parent, sibling, etc.)
Phone Number

ALL INFORMATION WILL REMAIN CONFIDENTIAL

FAMILY HISTORY

Has any member of your immediate family (parent, sibling, grandparent) had:

- Sudden death before 50? Yes☐ No☐ Who:
- Heart disease or High Blood Pressure? Yes☐ No☐ Who: mother
- Other Medical issues? Cancer, Diabetes, Liver disease, lung disease or other:

PAST MEDICAL HISTORY

Have you had any of the following?

	Yes	No		Yes	No
Heart Murmur	☐	☐	Dizziness – Fainting with Exercise	☐	☐
High Blood Pressure	☐	☐	Chest pain or palpitations	☐	☐
Mononucleosis	☐	☐	Past Surgery or Hospitalization	☐	☐
Epilepsy-Seizures	☐	☐	Asthma	☐	☐
Heat Exhaustion	☐	☐	Other Medical Problems?	☐	☐

If Yes to any, Explain:

Has a Doctor ever restricted your sport participation because of a heart Problem? **Yes:** ☐ **No:** ☐
Explain:

Do you cough, wheeze or have trouble breathing before or after activity? **Yes:** ☐ **No:** ☐
Explain:

I have a medical condition I would like to discuss with the Doctor **Yes:** ☐ **No:** ☐

COVID-19 HISTORY

Have any of the following applied to you:

Have you been diagnosed with COVID-19? **Yes:** ☐ **No:** ☐

If Yes, when?:

If YES, were you symptomatic? **Yes:** ☐ **No:** ☐

Have you experienced symptoms of COVID-19 an did not get tested? **Yes:** ☐ **No:** ☐

If YES, did you self-isolate / quarantine for 14 days? **Yes:** ☐ **No:** ☐

Have you ever come into contact with a confirmed COVID-19 case and did not undergo testing? **Yes:** ☐ **No:** ☐

Where you working or involved in a situation which may have put you at risk for COVID-19? **Yes:** ☐ **No:** ☐

If Yes, where?:

Do you understand the potential risks of COVID-19? **Yes:** ☐ **No:** ☐

IMMUNIZATIONS

This must be completed in FULL. Please provide the year of your last immunization for the following:

	Yes	**No**	YEAR
Tetanus/Diphtheria	☐	☐	
Measles/Mumps/Rubella	☐	☐	
Hepatitis B	☐	☐	
Meningitis	☐	☐	
Annual Flu Shot	☐	☐	
Chickenpox (Varicella)	☐	☐	

YOUR PARENTS OR FAMILY DOCTOR SHOULD HAVE THIS INFORMATION

ORGANS

Do you have any malfunctioning or missing organs? Yes ☐ No ☐

(I.e. Kidney, Liver, Spleen, Eye (vision), Ear (hearing), testicle, etc.)

Other:

MENTAL HEALTH

	Never (0)	Sometimes (1)	Mostly (2)
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 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	☐	☐	☐

MEDICATIONS AND ALLERGIES

List any and every medication and/or supplements you are now taking: (i.e. pills, patches, injections, inhaled, etc)

Do you have any allergies? Yes☐ No☐

If yes, what: Reaction:
If yes, what: Reaction:
If yes, what: Reaction:

VISION AND DENTAL

	Yes	**No**	
Do you wear glasses?	☐	☐	During Sport? ☐
Do you wear contacts?	☐	☐	During Sport? ☐
Do you have any other vision problems?	☐	☐	
Do you wear a mouth guard?	☐	☐	How old is it? under a year
Do you have dentures, false teeth or braces?	☐	☐	

ERGOGENIC SUPPLEMENTS REVIEW:

1) Are you taking any "over the counter" supplements? (Energy boosters, strength builders, vitamins?

Yes ☐ No ☐

If yes, please list:

2) Are you presently taking creatine? Yes ☐ No ☐

3) Have you taken creatine in the past? Yes ☐ No ☐

   When?

4) Are you presently taking any substances/supplements containing “ephedrine”? Yes ☐ No ☐

5) Have you taken supplements containing “ephedrine” in the past? Yes ☐ No ☐

   When?

6) Are you taking anything that you are not 100% sure about regarding its contents? Yes ☐ No ☐

   What?

7) Are you taking anything that claims to increase your energy or lose weight? Yes ☐ No ☐

   What?

8) Have you ever taken “anabolic steroids” Yes ☐ No ☐

   When? What type?

9) Have you ever taken precursors to anabolic steroids, such as Andro or DHE? Yes ☐ No ☐

   When?

Are you aware that USPORTS has drug testing? Yes ☐ No ☐

USPORTS strongly believes that the health and safety of players is vital to maintaining a strong and vibrant playing environment that is doping free. USPORTS is working with the Canadian Centre for Ethics in Sports to develop an anti-doping policy and players are subject to testing in the pre-season, regular season, and playoffs. Ignorance is not a defense and it is important to realize that supplements are not regulated products and may contain items from the banned list. http://www.cces.ca

*If you are taking anything that you are not 100% sure about regarding its contents, please discuss with the attending physician.

Signature of Athlete(use initials): TB Date:

FEMALE ATHLETE REVIEW

How old were you when you had your first menstruation?

How many periods have you had in the past 12 months?

Have you ever gone for more than 3 months without having a menstrual period? Yes ☐ No ☐

Normal Duration between periods in days?

Your last menstrual cycle:

Do you take birth control pills or hormones? Yes ☐ No ☐

Name:

Have you ever had a pap test? Yes ☐ No ☐

Most recent?

Have you ever been treated for anemia? Yes ☐ No ☐

LIFESTYLE & HEALTH ISSUES

1) Have you had any recent changes in weight? Yes ☐ No ☐

   If yes, how much?

2) Your highest weight as an adult? Your lowest weight as an adult?

   Current weight: Current height:

3) Are you satisfied with your weight? Yes ☐ No ☐

   If not, what would you like to weigh?

4) Have you ever tried to control your weight with (check if applicable):

☐ Fasting ☐ vomiting ☐ using laxatives ☐ diuretics ☐ diet pills

5) Are there certain food groups you avoid? Yes ☐ No ☐

   If yes, please list:

6) Do you have questions about healthy ways to control your weight? Yes ☐ No ☐

7) Do you have any dietary problems? Yes ☐ No ☐

   Please list:

8) Do you consume alcohol on most days? Yes ☐ No ☐

9) Do you chew or smoke tobacco? Yes ☐ No ☐

10) Have you used any recreational drugs in the past year? Yes ☐ No ☐
    If yes, please list:

TRAINING HISTORY

1) How old were you when you became active in competitive sport?
2) How many hours do you train for sport per week?
3) How many hours do you train beyond normal training times for your sport (i.e. on your own time outside of the structured practice training sessions)

HEAD INJURY HISTORY

1) Have you ever had a head injury or concussion? Yes ☐ No ☐

2) Have you ever been knocked out, become unconscious or lost your memory? Yes ☐ No ☐

3) Do you have headaches with exercise or frequent severe headaches? Yes ☐ No ☐

4) Have you had an MRI or CT scan of your head? Yes ☐ No ☐

5) Have you ever been referred to a Neurologist or concussion specialist? Yes ☐ No ☐

6) If yes to any of questions - please perform VOMS screening (Smooth Pursuit, Saccades Horizontal, Saccades Vertical, Convergence, VOR Horizontal, VOR Vertical and Visual Motion Sensitivity etc.)

Year	Sport	Loss of consci ousness?	How long?	Amnesia?	How long?	Seen by MD?	Kept in Hospit al?	How long off sports?	How long off school?	Still a problem?	Any Test (CT, MRI, EMG?)
		Yes ☐ No ☐		Yes ☐ No ☐		Yes ☐ No ☐	Yes ☐ No ☐			Yes ☐ No ☐	Yes ☐ No ☐
		Yes ☐ No ☐		Yes ☐ No ☐		Yes ☐ No ☐	Yes ☐ No ☐			Yes ☐ No ☐	Yes ☐ No ☐
		Yes ☐ No ☐		Yes ☐ No ☐		Yes ☐ No ☐	Yes ☐ No ☐			Yes ☐ No ☐	Yes ☐ No ☐
		Yes ☐ No ☐		Yes ☐ No ☐		Yes ☐ No ☐	Yes ☐ No ☐			Yes ☐ No ☐	Yes ☐ No ☐
		Yes ☐ No ☐		Yes ☐ No ☐		Yes ☐ No ☐	Yes ☐ No ☐			Yes ☐ No ☐	Yes ☐ No ☐
		Yes ☐ No ☐		Yes ☐ No ☐		Yes ☐ No ☐	Yes ☐ No ☐			Yes ☐ No ☐	Yes ☐ No ☐
		Yes ☐ No ☐		Yes ☐ No ☐		Yes ☐ No ☐	Yes ☐ No ☐			Yes ☐ No ☐	Yes ☐ No ☐
		Yes ☐ No ☐		Yes ☐ No ☐		Yes ☐ No ☐	Yes ☐ No ☐			Yes ☐ No ☐	Yes ☐ No ☐
		Yes ☐ No ☐		Yes ☐ No ☐		Yes ☐ No ☐	Yes ☐ No ☐			Yes ☐ No ☐	Yes ☐ No ☐
		Yes ☐ No ☐		Yes ☐ No ☐		Yes ☐ No ☐	Yes ☐ No ☐			Yes ☐ No ☐	Yes ☐ No ☐

MUSCULOSKELETAL INJURY HISTORY

Have you ever injured:	**Yes**	**No**	**Explanation**
Head/Face	☐	☐	
Neck	☐	☐	
Back	☐	☐	
Thoracic	☐	☐	
Lumbar	☐	☐	
Pelvis	☐	☐	
Chest & Ribs	☐	☐	
Abdomen	☐	☐	

Have you ever injured:	**Right**		**Left**		**Explanation**
	Yes	**No**	**Yes**	**No**	
Clavicle	☐	☐	☐	☐	
Acromioclavicular/AC Joint	☐	☐	☐	☐	
Shoulder	☐	☐	☐	☐	
Upper arm/Elbow	☐	☐	☐	☐	
Forearm/Wrist/Hand	☐	☐	☐	☐	
Hip/Groin	☐	☐	☐	☐	
Thigh/Hamstring	☐	☐	☐	☐	
Knee	☐	☐	☐	☐	
Lower leg/ankle/foot	☐	☐	☐	☐	

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 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, therapists, and/or administration information contained on this form or other information about my health status, as it relates to my participation at the University of Ottawa.

Date: Player's Signature:

Parent's signature if under 18 years of age: