

**UNIVERSITY OF NOTRE DAME HEALTH QUESTIONNAIRE**

Name \_\_\_\_\_ Notre Dame ID **9** \_\_\_\_\_ Birth date \_\_\_ / \_\_\_ / \_\_\_ Sport \_\_\_\_\_

<i>Explain "Yes" answers in the boxes below. Complete form on-line. Return via email or fax 574-631-5011</i>	YES	NO
1. Has a doctor ever denied or restricted your participation in a sport for any reason? If YES, explain: _____		
2. Do you have any ongoing or chronic medical conditions (like diabetes or asthma)? If YES, explain: _____		
3. Are you currently taking any medications (prescriptions, over-the-counter, herbs, vitamins or Supplements)? If YES, list: _____		
4. Do you have allergies to any medications, foods, pollens or stinging insects? If YES, list: _____		
5. Have you ever passed out or nearly passed out DURING exercise? If YES, explain: _____		
6. Have you ever passed out or nearly passed out AFTER exercise? If YES, explain: _____		
7. Have you ever had discomfort, pain, or pressure in your chest during exercise? If YES, explain: _____		
8. Does your heart race or skip beats during exercise? If YES, explain: _____		
9. Has a doctor ever told you that you have (check all that apply): High blood pressure ___ A heart murmur ___ High Cholesterol ___ A heart infection ___		
10. Has a doctor ever ordered a test for your heart (ECG, echocardiogram)? If YES, explain _____		
11. Has anyone in your family died before the age of 50 for no apparent reason? If YES, explain _____		
12. Does anyone in your family have Marfan's syndrome? If YES, explain _____		
13. Have you ever had surgery? If YES, explain: _____		
14. Have you ever had a stress fracture? If YES, explain _____		
15. Have you been told that you have, or had, a cervical spine (neck) problem? If YES, explain: _____		
16. Do you have asthma or any other lung condition? If YES, explain: _____		
17. Were you born without, or are you missing a kidney, an eye, a testicle, or any other organ? If YES, explain: _____		
18. Have you had infectious mononucleosis (mono) in the last 6 months? If YES, explain _____		
19. Have you ever had a head injury or concussion, or been confused and lost your memory after being hit in the head? If YES, explain _____		
20. Have you ever had a seizure? If YES, explain: _____		
21. Have you ever been unable to move your arms or legs after being hit or falling? If YES, explain: _____		
22. When exercising in the heat, do you have severe muscle cramps or become ill? If YES, explain: _____		
23. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? If YES, explain: _____		
<b>FEMALES ONLY:</b>		
Have you ever had a menstrual period?		
How old were you when you had your first menstrual period? _____		
How many periods have you had in the last year? _____		

**By signing this document, I am acknowledging that I have answered all questions truthfully. In addition by signing this document, I pledge to answer truthfully and completely all information relative to FUTURE injury and illness that may occur during the upcoming year.**

**Student Name** \_\_\_\_\_ **Date** \_\_\_\_\_  
*Signature* \_\_\_\_\_ *Print Name* \_\_\_\_\_