ALLERGIES

Belhaven University—Dance Department

PREPARTICIPATION HEALTH HISTORY EVALUATION*

**based on recommendations of the 2023 American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, American Osteopathic Academy of Sports Medicine, and NCAA Mental Health Best Practices Manual*

PLEASE PRINT CLEARLY

Name ____ Sex M F Age ____ Date of Birth _____________
Permanent Address ____________________________________ Student Cell Number ____________________________
City ______________________ State ________ Zip __________
Emergency Contact ____ Relationship to student_____________
Emergency Contact's Phone Number ________________________

PLEASE EXPLAIN ANY "YES" ANSWERS ON LINES BELOW.

1. Have you had a health problem (physical or mental) or injury since your last physical? ❑ Yes ❑ No

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2. Do you have an ongoing or chronic physical or mental health condition (Ex. ADHD, anxiety, depression, CRPS, Ehlers-Danlos, Epilepsy, etc)? ❑ Yes ❑ No

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3. Have you ever had surgery? ❑ Yes ❑ No

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4. Are you currently taking any prescription or nonprescription (over the counter) medications, supplements, or using an inhaler? ❑ Yes ❑ No

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5. Do you have any allergies (i.e. pollen, medicine, food, or stinging insects)? ❑ Yes ❑ No

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6. Have you every passed out or nearly passed out during or after exercise? ❑ Yes ❑ No
   - Have you ever had chest pain, discomfort, tightness, or pressure during or after exercise? ❑ Yes ❑ No
   - Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise? ❑ Yes ❑ No
   - Has a doctor ever told you that you have any heart problems (i.e. heart murmur, irregular heartbeat, etc)? ❑ Yes ❑ No
   - **Has a doctor ever requested a test for your heart? For example,** electrocardiography (ECG) or echocardiography. ❑ Yes ❑ No
   - Do you get light-headed or feel shorter of breath than your friends during exercise? ❑ Yes ❑ No
   - Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 (including drowning or unexplained car crash)? ❑ Yes ❑ No
   - **Does anyone in your family have a genetic heart problem such as** hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)? ❑ Yes ❑ No
   - **Has anyone in your family had a pacemaker or an implanted defibrillator** before age 35? ❑ Yes ❑ No
   - Has a physician ever denied or restricted your participation in sports, exercise, or performing arts for any heart problems? ❑ Yes ❑ No

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7. Have you ever had a head injury or concussion that caused confusion, a prolonged headache, or memory problems? ❑ Yes ❑ No
   - Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling? ❑ Yes ❑ No
   - Do you have frequent or severe headaches? ❑ Yes ❑ No
   - Have you ever had a stinger, burner, or pinched nerve? ❑ Yes ❑ No
   - Have you ever had a seizure? ❑ Yes ❑ No
   - **Do you have Epilepsy?** ❑ Yes ❑ No
   - **If you have Epilepsy, do you know your triggers?** ❑ Yes ❑ No

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8. Do you or does someone in your family have sickle cell trait or disease? ❑ Yes ❑ No ❑ Unsure

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9. Have you ever become ill from exercising in the heat? ❑ Yes ❑ No

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10. Do you cough, wheeze, or have trouble breathing during or after activity? ❑ Yes ❑ No
    - Do you have asthma? ❑ Yes ❑ No
    - Do you have seasonal allergies that require medical treatment? ❑ Yes ❑ No

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11. Have you ever had a sprain or strain?
❏ Yes ❏ No
●Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a rehearsal or performance? ❏ Yes ❏ No
●Do you have a bone, muscle, ligament, or joint injury that currently bothers you? ❏ Yes ❏ No
If YES, check the appropriate box(es) and explain below.
❏ Head ❏ Elbow ❏ Hip
❏ Neck ❏ Forearm ❏ Thigh
❏ Back ❏Wrist ❏ Knee
❏ Chest ❏ Hand ❏ Shin/calf
❏ Shoulder ❏ Finger ❏ Ankle
❏ Upper arm ❏ Foot
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12. Have you ever had or do you have any problems with your eyes or vision? ❏ Yes ❏ No
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13. Do you worry about your weight? ❏ Yes ❏ No
●Are you trying to or has anyone recommended that you gain or lose weight? ❏ Yes ❏ No
●Are you on a special diet or do you avoid certain types of foods or food groups? ❏ Yes ❏ No
●Have you ever had an eating disorder? ❏ Yes ❏ No
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FEMALES ONLY
14. Have you ever had a menstrual period? ❏ Yes ❏ No
●Approximately, how old were you when you had your first menstrual period? ___________________
●When was your most recent menstrual period? ________________
●How many periods have you had in the past 12 months? _________

Over the past month,
15. ●Do you feel stressed out during dance activities? ❏ Yes ❏ No
●Do you often have trouble sleeping? ❏ Yes ❏ No
●Do you wish you had more energy most days of the week? ❏ Yes ❏ No
●Do you think about things over and over? ❏ Yes ❏ No
●Do you feel anxious and nervous much of the time? ❏ Yes ❏ No
●Do you often feel sad or depressed? ❏ Yes ❏ No
●Do you struggle with being confident? ❏ Yes ❏ No
●Do you feel hopeful about the future? ❏ Yes ❏ No
●Do you have a hard time managing your emotions (anger, frustration, impatience)? ❏ Yes ❏ No
●Do you ever have feelings of hurting yourself or others? ❏ Yes ❏ No

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Dancer _______________________________________ Parent/Guardian (dancers under 18) _____________________________ Date ___________________

If you are having difficulty reading this document please contact the Belhaven University Dance Department and we will assist you.