جامعة قطر
QATAR UNIVERSITY

History and Medical Information

Form 1: Students Applying to Athletic Scholarships

(Note: please fill this form by yourself or with a parent/guardian before seeing a health care provider)

Name _____ Date _____

Date of Birth _____ gender _____

Sport(s) _____

Medicines and Allergies: If you are taking any medicines or supplements (herbal and nutritional), please list them below

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, indicate them below

☐ Food ☐ Medicines ☐ Pollens ☐ Stinging Insects

Explain all answers "Yes" in the space below. Circle the number of the questions you do not understand or do not have a certain answer to.

GENERAL QUESTIONS	**Yes**	**No**
1. Have you ever been asked to take a time off from participating in sports from your doctor?		
2. Do you have any current medical conditions? If yes, please indicate below: ☐ Diabetes ☐ Anemia ☐ Asthma ☐ Infections Other: _____		
3. Have you ever been hospitalized or slept at the hospital?		
4. Did you undergo any surgery?		
QUESTIONS ABOUT YOUR HEART HEALTH	**Yes**	**No**
5. Did you ever faint or lost consciousness while exercising?		
6. Did you ever feel any unexplained lightheadedness, chest pain or tightness of breath during exercise?		
7. Did you ever feel that your heart is beating irregularly during exercise?		
8. Do you have any problems related to your heart? If yes, please indicate below: ☐ High cholesterol ☐ High blood pressure ☐ Heart infection ☐ Heart murmur Other: _____		
9. Were you ever asked by your doctor to do a cardiac (heart) test? (e.g., ECG or EKG)		
10. Did you ever suffer from an unexplained seizure?		

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QUESTIONS RELATED YOUR FAMILY	Yes	No
11. Did you ever lose any family member from heart problems or from a sudden death that was unexplained before the age 50?		
12. Does any of your family members suffer from a heart problem, or has a pacemaker, or implanted defibrillator?		
13. Do you have any family member that had an unexplained fainting or seizure?		
MUSCULOSKELETAL QUESTIONS	**Yes**	**No**
14. Have you ever suffered from an injury (e.g., ligament, muscle, bone, tendon, dislocated joint) resulting in missing a game or a training session?		
15. Did you ever have to do an x-ray, CT scan, or MRI, injections, therapy, or wear a cast, crutches or brace?		
16. Have you ever suffered from a neck problem or instability or atlantoaxial instability? (dwarfism or down syndrome)		
17. Do you usually use any assistive devices (e.g., brace, orthotics)?		
18. Are you still bothered by any muscle, joint or bone injury you had in the past?		
19. Do you ever feel pain, swelling, warmth or redness in any of your joints?		
20. Have you ever suffered from a disease in connective tissue or early arthritis?		
CLINICAL QUESTIONS	**Yes**	**No**
21. Have you ever experience coughing, wheezing, or a difficulty in breathing during or after exercising?		
22. Do you ever use an inhaler?		
23. Do you have any family member who has asthma?		
24. Do you have any missing or malfunctioning organ (kidney, spleen, a testicle for males, an eye)?		
25. Do you suffer from any pain in the groin area (e.g., unexplained pain, hernia or painful bulge)?		
26. Did you suffer from infectious mononucleosis in the last 30 days?		
27. Do you currently have any skin problems (e.g., rashes, pressure sores)?		
28. Did you ever have any skin infection (e.g., herpes or MRSA)?		
29. Did you ever have a concussion or injury to the head that resulted in confusion, memory loss or chronic headache or migraine?		
30. Do you often or usually have headaches when you exercise?		
31. Have you ever suffered from a seizure disorder?		
32. Have you ever been incapable of moving your limbs or felt a tingling, numbness, or weakness sensation in your arms or legs as a result of falling or receiving a hit?		
33. Did you ever feel ill when exercising in a hot or humid environment?		

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34. Do you frequently get cramps in your muscles while exercising?		
35. Do you or any of your family members have sickle cell trait or disease?		
36. Do you have any vision or eye problem or have you had any injury to your eye?		
37. Do you wear glasses or contact lenses?		
38. Does your current weight worry you or has anyone advised you to gain or lose weight?		
39. Do you currently follow a specific diet or are you avoiding specific categories of food?		
40. Have you ever suffered from an eating disorder?		
41. Are there any specific concerns that you would like to share with a physician or health care provider?		
FEMALES ONLY	**Yes**	**No**
42. Did you ever have a menstrual period?		
43. How old were you when you first had your menstrual period?		
44. How many times, on average, did you have your menstrual period in the last year?		

Explain if the answer is "no":

_____
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Information provided in this form will be kept confidential, but may be shared to coaches, physiotherapists and health specialists at the university to ensure safe participation.

I confirm that I have answered this form correctly and completely to the best of my knowledge.

Signature of athlete _____ Date _____

Signature of parent/guardian (if under 18) _____ Date _____