Tulane INSTITUTE OF Sports Medicine

Female Pre-Participation Questionnaire

Name_____ **Age**____**Date**_____**School**_____

Athletic History

1) What is your primary sport? _____
2) How many sports do you play or compete in? Please list specific sports.
   _____
   _____
3) Please describe the pre-season practice schedule for each sport. (eg number of times/day, length of each practice; focus of the practice [ie weight training, skills training])
   _____
   _____
   _____
4) While in season, do you practice daily?
   - ☐ Yes – please list number of hours/day _____
   - ☐ No
5) If you do not practice daily while in season, indicate how many days/week you practice: _____
6) While in season, do you practice more than once/day?
   - ☐ Yes – please indicate how many times/day _____
   - ☐ No
7) Do you participate in weight training?
   - ☐ Yes – Please describe_____
   - ☐ No
8) Have you ever had a concussion?
   - ☐ Yes – please specify number of times _____
   - ☐ No
9) Have you ever been injured while playing sports?
   - ☐ Yes – please describe the nature of the injury and the treatment (eg therapy, surgery)
     _____
     _____
     _____
     _____
   - ☐ No
10) Do you still play the sport that caused the injuries listed in question **#9**?
   - ☐ Yes – I am back to playing at the same level in that sport as before the injury
   - ☐ Yes – but I am not able to play at the same level in that sport as before the injury
   - ☐ No
   - ☐ N/A

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Female Pre-Participation Questionnaire

Menstrual History

1) Have you ever had a menstrual period? Yes ☐ No ☐
2) How old were you when you had your first menstrual period? ____Years
3) When was your most recent menstrual period? _____
4) How many periods have you had in the past 12 months? _____
5) Are you currently taking any female hormones (estrogen, progresterone, birth control pills?)
   - ☐ Yes – please specify which _____
   - ☐ No
6) If you take birth control pills, please indicate how long you have been taking them? _____

Nutrition/Wellness

1) Do you worry about your weight? Yes ☐ No ☐
2) Are you trying to gain weight? Yes ☐ No ☐
3) Are you trying to lose weight? Yes ☐ No ☐
4) Has anyone recommended that you lose weight? Yes ☐ No ☐
5) Has anyone recommended that you gain weight? Yes ☐ No ☐
6) Are you on a special diet or do you avoid certain types of food or food groups?
   - ☐ Yes – please explain _____
   - ☐ No
7) Have you ever had inconsistent eating habits?
   - ☐ Yes - please explain _____
   - ☐ No
8) Do you take vitamin D and/or calcium?
   - ☐ Yes – vitamin D only
   - ☐ Yes – vitamin D and calcium
   - ☐ Yes – calcium only
   - ☐ No
9) On average, how many hours/night do you sleep? _____

Bone Health

1) Have you ever had a stress fracture?
   - ☐ Yes – please specify location _____
   - ☐ No
2) Have you ever been told you have low bone density (osteopenia or osteoporosis)?
   - ☐ Yes – osteopenia
   - ☐ Yes – osteoporosis
   - ☐ Yes – I'm not sure whether it was osteopenia or osteoporosis
   - ☐ No
3) Have you ever had a bone density test (ie DEXA scan)?
   - ☐ Yes – please specify when _____
   - ☐ No

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