

Lock Haven Athletic Training Supplemental Female History

Dear Female Student Athlete,

The following form is a supplement to the Lock Haven University Pre-season Physical Form. The Supplemental History for Female Athletes Form has been designed to help Lock Haven University Athletic Training Staff to meet the special needs of the competitive female athlete. Many of these questions are of a personal nature. We ask that you answer each question as honestly and completely as possible. These forms will be held in complete confidentiality, with only the Certified Athletic Training Staff and Team Physicians gaining access to the Information. We appreciate your assistance in completing this form so we may better serve you in your athletic endeavors.

Name: _____ Sport(s): _____
Last First MI

At what age did you have your first menstruation?		_____
How many days does your period last?		_____
How many days between periods?		_____
How many periods have you had in the last 12 months?		_____
What is the date of your last menstrual period?		_____
Have you had irregular menstrual cycles?	YES	NO
Have you ever stopped having your menstrual cycle?	YES	NO
Have you ever experienced heavy bleeding?	YES	NO
Have you ever had a pelvic exam? If yes, when was your last?		_____
Have you ever had a breast exam? If yes, when was your last?		_____
Have you ever had an abnormal:		
Pelvic Exam	YES	NO
Breast Exam	YES	NO
Pap Smear	YES	NO
Do you or have you ever taken birth control pills?	YES	NO
Do you or have you ever taken hormones?	YES	NO
Have you ever had a stress fracture?	YES	NO
Is there a family history of osteoporosis?	YES	NO
Are you unhappy with your present weight?	YES	NO
If yes, what is your desired weight?		_____
Do you have trouble maintaining your desired weight?	YES	NO
Have you been instructed to diet/lose weight by a coach?	YES	NO
Do you diet regularly?	YES	NO
Do you feel out of control with your eating habits?	YES	NO
Have you ever tried to control your weight by:		
Vomiting	YES	NO
Using Diet Pills	YES	NO
Using Laxatives	YES	NO
Using Diuretics	YES	NO
Excessive Exercise	YES	NO
Have you been diagnosed with an eating disorder?	YES	NO
How many meals do you eat a day?		_____
Would you like to talk to a professional about your eating habits?	YES	NO

If you answered yes to any questions, please explain: _____
