UNIVERSITY HEALTH SERVICES
SUPPLEMENTAL HISTORY FORM FOR THE FEMALE ATHLETE:

NAME: ______________________________ **Date of Birth** _________ **Class** _____ **Sport**________________________

1 How old were you when you had your first menstrual cycle? ____________________________________

2 How many days do you have menstrual bleeding? _____ What is the date of your last menstrual cycle? _____

3 How may periods have you had in the past 12 months? ___________________________

4 Do you ever have cramping with your period? Y N

5 If yes, what do you do to lessen your symptoms? ___________________________

6 Have you ever had “irregular” cycles? Y N

If yes, circle < 21 days, > 35 days between cycles?

7 Have you ever had heavy bleeding? Y N

8 Have you ever stopped having your period? Y N

If yes, when and for how long? Give details months /years) ____________________________

9 Have you ever had a stress fractures? Y N

If yes, please list sites, dates, method of diagnosis (x-ray, bone scan, etc.) ______________________________

10 Is there any family history of osteoporosis (thinning of bone)? ______________________________________

11 When was your last pelvic exam? _______________________ Last breast exam? _______________________

12 Have you ever had an ABNORMAL pelvic exam or PAP smear? ___________________________________

13 a. Are you currently taking oral contraceptives or hormones? Y / N

If yes why: (circle) birth control / irregular menses / no menses / painful menses / other

b. Have you ever taken oral contraceptives or hormones? Y / N

If yes why? (circle) birth control / irregular menses / no menses / painful menses / other

14 Has a physician ever told you that you had anemia?(low hematocrit or iron) __________________________

15 What is your present weight? ______ Present height? ______

16 Are you happy with your present weight Y / N If not, what is your desired weight? _______________

17. How many meals do you eat a day? _____ Do you take vitamins or supplements? _____________

18 Highest weight: _____ Lowest Weight: _____ Do you have trouble maintaining your optimal weight? Y / N

19 On an average in two days, how may servings of each do you eat? (please circle)

Grains (cereal, bread, rice pasta)	0,1,2,3,4,>4	Fruits	0,1,2,3,4,>4
Dairy products (milk, yogurt, cheese)	0,1,2,3,4,>4	Red Meats	0,1,2,3,4,>4
Beans, nuts, tofu	0,1,2,3,4,>4	Vegetables	0,1,2,3,4,>4
Chicken, fish	0,1,2,3,4,>4	Eggs	0,1,2,3,4,>4

20 Do you ever feel out of control with your eating behaviors Y / N

21 Have you ever tried to control your weight by: Dieting/fasting: Y / N Diet pills: Y / N

Diuretics: Y / N Vomiting: Y / N Excessive Exercise: Y / N

22 Have you ever had an eating disorder? __________________

Athlete Signature ____ **Today’s Date** __________