Pine Manor College Sports Medicine

400 Heath Street
Chestnut Hill, MA 02467

Instructions for Completion

- Student-Athletes that fail to complete the pre-participation medical screening form completely and accurately will not be allowed to begin practicing with their team.

- The information provided should encompass your entire life medical history. All injuries, illnesses, medical procedure, surgeries and pertinent family history should be included.

- Mark "Yes" or "No" next to each item that corresponds to a medical or health issue on the following pages.
  - If an item is marked "yes': Please describe in detail the condition and/or concern in the space provided. Be sure to include dates when possible
  - Include any ongoing medical care that you are receiving.
  - Please indicate if you currently have any restrictions or limitations due to a particular condition.

Diseases and Illness:

1.) Have you ever suffered from heat illness or heat stroke? ☐ Yes ☐ No

2.) Have you ever had one of the following?

a. Chicken Pox ☐ Yes ☐ No
b. Hepatitis ☐ Yes ☐ No
c. Mumps/Measles ☐ Yes ☐ No
d. Bleeding Disorder ☐ Yes ☐ No
e. Rheumatic fever/Whooping cough ☐ Yes ☐ No

3.) Have you ever been treated for Mononucleosis (Mono), pneumonia or any other infectious diseases? ☐ Yes ☐ No

4.) Have you ever had the following symptoms of heart problems?

a. Chest Pains ☐ Yes ☐ No
b. Fatigue easily ☐ Yes ☐ No
c. Heart murmur/irregular heartbeat/arrhythmia ☐ Yes ☐ No
d. Shortness of breath ☐ Yes ☐ No
e. EKG/Abnormal EKG ☐ Yes ☐ No

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5.) Have you ever been tested for sickle cell anemia for sickle cell trait? ☐ Yes ☐ No

6.) Have you ever been diagnosed with sickle cell anemia or sickle cell trait? ☐ Yes ☐ No

7.) Have you ever had a history of a chronic lung condition (i.e. Asthma or Bronchitis)? ☐ Yes ☐ No

8.) Do you have a history of high/low blood pressure or cholesterol? ☐ Yes ☐ No

9.) Have you ever been diagnosed with epilepsy or had a seizure? ☐ Yes ☐ No

10.) Have you ever passed out or fainted during exercise? ☐ Yes ☐ No

11.) Any other major diseases or illnesses not discussed? ☐ Yes ☐ No

Family History:

1.) Are all members of your immediate family (mother, father, siblings) in good health? ☐ Yes ☐ No

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2.) Has anyone in your family been diagnosed or treated for the following illnesses?

- a. Diabetes ☐ Yes ☐ No
- b. Sickle Cell Anemia/Trait ☐ Yes ☐ No
- c. Marfan's Syndrome ☐ Yes ☐ No
- d. Epilepsy/Seizures ☐ Yes ☐ No
- e. Cancer ☐ Yes ☐ No
- f. High/Low Blood Pressure or cholesterol ☐ Yes ☐ No
- g. Mental Health Disorder ☐ Yes ☐ No
- h. Other ☐ Yes ☐ No

3.) Has anyone in your family under the age of 50 died from heart disease? ☐ Yes ☐ No

4.) Has anyone in your family had the following symptoms of heart problems?

- a. Chest Pains ☐ Yes ☐ No
- b. Fatigue easily ☐ Yes ☐ No
- c. Heart murmur/irregular heartbeat/arrhythmia ☐ Yes ☐ No
- d. Shortness of breath ☐ Yes ☐ No

Allergies/Medications:

1.) Are you currently taking any prescription medication regularly (i.e. Birth control)? ☐ Yes ☐ No

2.) Are you currently taking any over the counter medication regularly (i.e. Advil/Tylenol)? ☐ Yes ☐ No

3.) Are you allergic to any medication (prescription or OTC)? ☐ Yes ☐ No

4.) Are you currently taking prescription medication for ADD/ADHD? ☐ Yes ☐ No

5.) Do you have any environmental or food allergies? ☐ Yes ☐ No

Orthopedic Injuries:

1.) Do you currently have an orthopedic injury that would limit your participation in athletics? ☐ Yes ☐ No

2.) Have you ever had one of the following shoulder injuries?
- a. Dislocation ☐ Yes ☐ No
- b. AC separation ☐ Yes ☐ No
- c. Impingement ☐ Yes ☐ No
- d. Tendonitis ☐ Yes ☐ No

3.) Have you ever experienced an elbow/forearm injury? ☐ Yes ☐ No

4.) Have you ever experienced an injury to any of the following structures?
- a. Hand ☐ Yes ☐ No
- b. Wrist ☐ Yes ☐ No
- c. Fingers ☐ Yes ☐ No
- d. Thumb ☐ Yes ☐ No

5.) Have you ever experienced a hip/thigh injury? ☐ Yes ☐ No

6.) Have you ever had one of the following knee injuries?
- a. Ligament tear (ACL, MCL, PCL, LCL) ☐ Yes ☐ No
- b. Meniscus ☐ Yes ☐ No
- c. Tendonitis (Jumper's Knee, Osgood Schlatters) ☐ Yes ☐ No
- d. Fractures ☐ Yes ☐ No

7.) Have you ever experienced an injury to any of the following structures?

- a. Lower Leg ☐ Yes ☐ No
- b. Ankle ☐ Yes ☐ No
- c. Foot ☐ Yes ☐ No
- d. Toes ☐ Yes ☐ No

8.) Have you ever suffered from "shin splints" or lower leg stress fractures? ☐ Yes ☐ No

9.) Have you ever experienced a back injury? ☐ Yes ☐ No

10.) Have you ever been diagnosed with scoliosis? ☐ Yes ☐ No

11.) Have you ever been advised to have surgery or physical therapy on any joint? ☐ Yes ☐ No

12.) Do you wear braces or orthotics? ☐ Yes ☐ No

13.) Do you have any other orthopedic injuries that you have not yet discussed? ☐ Yes ☐ No

Head and Neck Injuries:

1.) Have you ever had a concussion (i.e. "bell rung" or "knocked out)? ☐ Yes ☐ No
If "Yes", How many?

2.) Have you ever been hospitalized due to a head injury? ☐ Yes ☐ No

3.) Have you ever severely injured/fractured any of the following structures?

- a. Nose ☐ Yes ☐ No
- b. "Eye Socket" ☐ Yes ☐ No
- c. Cheek Bone ☐ Yes ☐ No
- d. Jaw/teeth ☐ Yes ☐ No

4.) Do you suffer from chronic or severe headaches/Migraines? ☐ Yes ☐ No

5.) Have you ever experienced a neck injury? ☐ Yes ☐ No

6.) Have you ever experienced any numbness or tingling in your arms, hands, legs or feet? ☐ Yes ☐ No

Surgery/Other Medical Conditions:

1.) Have you ever had an operation of any kind (i.e. Tonsillectomy, Wisdom teeth)? ☐ Yes ☐ No

2.) Do you have a metal plate, screw or rod anywhere in your body? ☐ Yes ☐ No

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3.) Have you ever had any problems with any of the following?

a. Kidneys ☐ Yes ☐ No
b. Reproductive Organs ☐ Yes ☐ No
c. Spleen/Liver ☐ Yes ☐ No
d. Stomach/Intestines ☐ Yes ☐ No
e. Thyroid Gland ☐ Yes ☐ No
f. Other ☐ Yes ☐ No

4.) Have you ever been involved in a motor vehicle accident? ☐ Yes ☐ No

5.) Do you wear glasses or contacts regularly and/or during athletic completion? ☐ Yes ☐ No

6.) Have you ever been advised by a physician not to participate in athletics? ☐ Yes ☐ No

Gynecological/Psychological/Body Composition:

1.) Do you have a history of irregular menstrual periods? ☐ Yes ☐ No

2.) Have you ever missed your period for 3 consecutive months or more? ☐ Yes ☐ No

3.) Do you suffer from severe cramps or excessive flow? ☐ Yes ☐ No

4.) Have you had a routine pelvic exam by an OB/GYN? ☐ Yes ☐ No

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5.) Have you ever had an abnormal PAP smear? ☐ Yes ☐ No

6.) Have you ever been diagnosed or concerned with having any of the following?

a. Eating Disorder ☐ Yes ☐ No
b. Anxiety Disorder ☐ Yes ☐ No
c. Depression ☐ Yes ☐ No
d. Bi Polar Disorder ☐ Yes ☐ No
e. Other ☐ Yes ☐ No

7.) Has you weight increased or decreased by 15lbs in the last year? ☐ Yes ☐ No

Other:

1.) Do you know of any health reason which may affect your participation in athletics? ☐ Yes ☐ No