

Medical Information Update

✓ Check “yes” if you have had any of the following conditions in the *last calendar year*:

- | | | | |
|---|--|--|--|
| 1. Did you develop an illness requiring medical attention? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 26. Have you developed any allergies (e.g. pollen, medicine, food, or stinging insect)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Have you been hospitalized overnight? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 27. Did you develop any skin problems (e.g. acne, itching, rashes, warts, fungus, or blisters)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Have you had surgery? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 28. Has any family member or relative died of heart problems or sudden death before age 50? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Have you lost or developed a problem with any paired organ (e.g. eyes, testicles, kidneys, breasts)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 29. Have you been diagnosed or treated for a mental health disorder? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Have you had chest pain or trouble breathing during or after exercise? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 30. Have you been diagnosed with or treated for an eating disorder? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Have you felt dizzy or passed out during or after exercise? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 31. Have you consulted a Nutritionist? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Have you noticed that you get tired more quickly during exercise? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 32. Would you consider yourself to have disordered eating? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Have you developed asthma? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 33. Has your weight fluctuated more than 15 lbs? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Have you had a racing heart rate, irregular, extra, or skipped beats? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 34. Did you lose weight to meet sport weight limit requirements? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Have you become ill from exercising in the heat? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 35. Have you recently begun a weight loss program? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Have you developed high blood pressure or high cholesterol? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 36. Have you started taking any supplements or vitamins to help you gain or lose weight or to improve your performance (e.g. Creatine, hydroxycut)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12. Have you been told you have a heart murmur? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 37. Have you started to wear glasses, contacts, or protective eyewear? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 13. Have you had an EKG? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 38. Have you begun to use any special protective or corrective equipment or devices that aren't usually used for your sport or position (e.g. knee brace, orthotics, retainer, hearing aid)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 14. Have you been tested for sickle-cell trait? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 39. Are you under observation by a physician for a problem? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 15. Have you discovered you have sickle-cell trait? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 40. Have you experienced irregular menstrual periods? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 16. Have you broken or fractured any bones or dislocated any joints? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 41. Have you missed your period for 3 consecutive months or more? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 17. Are you currently taking any prescription or non-prescription (over-the-counter) medications, pills, or an inhaler? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 42. Have you had an abnormal PAP smear or pelvic exam by an OB/GYN? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 18. Have you had any seizures? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 43. Has a physician denied or restricted your participation in sports for any reason? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 19. Did you experience a head injury or concussion? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 44. Have you had any problems with pain or swelling in muscles, tendons, bones or joints? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 20. Have you been knocked out, become unconscious, or lost your memory? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 21. Did you develop frequent or severe headache? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 22. Have you had numbness or tingling in your arms, hands, legs, or feet? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 23. Have you had any problems with your eyes or vision? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 24. Do you have any incompletely healed or non-rehabilitated injury? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Have you developed a severe viral infection (e.g. mononucleosis or myocarditis)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

IF YOU ANSWERED “YES” TO ANY QUESTION, PLEASE PROVIDE THE ITEM NUMBER, DATE AND OUTCOME OF ALL CONDITIONS LISTED ABOVE.

GATORS
PINE MANOR COLLEGE