

Pine Manor College Sports Medicine

400 Heath Street
Chestnut Hill, MA 02467

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

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

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

7.) Have you ever been diagnosed with epilepsy or seizures? _____ Yes No

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

9.) 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

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

- a. Diabetes..... Yes No
- b. Sickle Cell 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

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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

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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

6.) 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 Slaughter's)..... 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

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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

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

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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

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

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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

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

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7.) Has your 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