

**SIMMONS COLLEGE  
HEALTH CENTER/SPORTS MEDICINE DEPARTMENT  
ATHLETIC CLEARANCE  
MEDICAL HISTORY AND PHYSICAL EXAM**

**Name** \_\_\_\_\_ **Age** \_\_\_\_\_ **DOB** \_\_\_\_\_

**Sport(s)** \_\_\_\_\_ **College year: Fr Soph Jr Sr**

**Local address** \_\_\_\_\_ **Cell #** \_\_\_\_\_

**Parent/Guardian name(s)** \_\_\_\_\_

**Parent/Guardian address(es)** \_\_\_\_\_

**Parent/Guardian phone** \_\_\_\_\_ **Today's date** \_\_\_\_\_

**Emergency contact name** \_\_\_\_\_ **Phone #** \_\_\_\_\_

**Emergency contact's relationship to you** \_\_\_\_\_

**MEDICAL HISTORY**

<b>Do you have or have you had....</b>	<b>Yes</b>	<b>No</b>	<b>Provider comments</b>
Over-the-counter or prescription medications that you currently take on a regular or as needed basis? List:			
Allergy to medication or food? Describe:			
Epilepsy or history of seizure			
Diabetes			
Anemia			
Hemophilia or other bleeding disorder			
Sickle cell disease or trait			
Asthma			
Dissatisfaction with your eating patterns			
Absence of any organ or body part			
High blood pressure			
Heart murmur or other cardiac problem			
Times when you eat in secret			
A sense that your weight affects the way you feel about yourself			

**Name** \_\_\_\_\_ **Date** \_\_\_\_\_

<b>Do you have or have you had....</b>	<b>Yes</b>	<b>No</b>	<b>Provider comments</b>
Passed out or nearly passed out during or shortly after exercise			
Chest discomfort, pain, heaviness or pressure during exercise			
Palpitations, racing heart, skipped heart beats			
Kidney/bladder disease			
Cancer			
Vomiting because you feel uncomfortably full			
HIV infection			
Thyroid problem			
Hernia			
Been told you have Marfan Syndrome			
“Double-jointedness”			
Eating disorder			
Been told you had heat stroke or other heat-related illness			
Depression, anxiety, other psychological issue			
Ongoing diarrhea or blood in stool			
MD advice to avoid sports			
History of use of performance enhancing substances			
History of tobacco use			
History of alcohol or other substance abuse			
Loss of consciousness, head injury, or concussion (describe)			
Neck injury or surgery or “stinger” (pins and needles in arm(s) after injury (describe)			
Shoulder injury (describe)			
Shoulder surgery (describe)			
Back or spine injury (describe)			
Back or spine surgery (describe)			
Hip or pelvic injury (describe)			

Name \_\_\_\_\_

Date \_\_\_\_\_

Do you have or have you had....	Yes	No	Provider comments
Hip or pelvic surgery (describe)			
Knee injury or surgery (describe)			
Upper or lower leg injury (describe)			
Upper or lower leg surgery (describe)			
Ankle injury (describe)			
Ankle surgery (describe)			
Arm, hand, elbow, wrist injury (describe)			
Arm, hand, elbow, wrist surgery (describe)			
Metal implant (pin, plate, screw, etc) where?			
Back pain			
Other medical issues not already addressed (describe)			
Parent or sibling with heart disease at a relatively young age, bleeding disorder, phlebitis (blood clot), eating disorder			
Do you ever fast for religious or other reasons? Explain:			
Are you vegan?			
Have you ever needed extra protective equipment during sports? Describe:			
# of menstrual periods in the past 12 months			

**I certify that the answers to these questions are correct and that I am not withholding medical information from the Health Center or Sport Medicine staff.**

\_\_\_\_\_  
**(Athlete's Signature)**

\_\_\_\_\_  
**(Date)**

\_\_\_\_\_  
**(Athletic Trainer's Signature)**

\_\_\_\_\_  
**(Date)**