

**SIMMONS COLLEGE  
SPORTS MEDICINE DEPARTMENT  
MEDICAL HISTORY FORM**

**Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Birthday:** \_\_\_\_\_

**Sport(s):** \_\_\_\_\_ **Year in College:** Fr. Soph. Jr. Sr.

**Local Address:** \_\_\_\_\_ **Cell Phone #:** \_\_\_\_\_

**Parent's/Guardian's Name:** \_\_\_\_\_ / \_\_\_\_\_

**Parent's/Guardian's Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_

**Parent's/Guardian's Telephone #:** (       ) \_\_\_\_\_

**Emergency Contact Person's Name:** \_\_\_\_\_

**Emergency Contact's Number:** (       ) \_\_\_\_\_

**Emergency Contact's Relationship to Student-Athlete:** \_\_\_\_\_

**Today's Date:** \_\_\_\_\_

**YES NO** 1. Are you allergic to any substances and/or medications? List: \_\_\_\_\_  
\_\_\_\_\_

**YES NO** 2. Do you take any medications on a regular basis? List: \_\_\_\_\_

**YES NO** 3. Do you have epilepsy, or ever suffered a seizure? Date of last seizure: \_\_\_\_\_

**YES NO** 4. Have you been treated for diabetes? Medication: \_\_\_\_\_

**YES NO** 5. Has a physician ever told you that you are anemic?

**YES NO** 6. Have you ever been diagnosed with Sickle Cell Disease?

- YES NO** 7. Have you ever been told that you are a carrier of the Sickle Cell Trait?
- YES NO** 8. Have you ever been diagnosed with the following (circle all that apply):  
                     High Blood Pressure    Heart Murmur    Heart Infection
- YES NO** 9. Have you ever passed out or nearly passed out DURING exercise?
- YES NO** 10. Have you ever passed out or nearly passed out AFTER exercise?
- YES NO** 11. Have you ever had discomfort, pain, or pressure in your chest during exercise?
- YES NO** 12. Have you had any of the following diseases (circle all that apply):  
                     Heart                      Kidney                      Lung                      Liver
- YES NO** 13. Do you have asthma?    Medication: \_\_\_\_\_
- YES NO** 14. Have you ever had a hernia?    Has it been repaired? \_\_\_\_\_
- YES NO** 15. Have you ever been knocked unconscious?    Date: \_\_\_\_\_
- YES NO** 16. Have you ever had a head injury or concussion?    Date: \_\_\_\_\_
- YES NO** 17. Have you ever had a neck injury involving bones, nerves, or discs (stingers, fractures, loss of feeling, numbness, or pain)?    Date and type: \_\_\_\_\_
- YES NO** 18. Have you ever had a shoulder injury?    Date and type: \_\_\_\_\_
- YES NO** 19. Have you ever had shoulder surgery?    Date and type: \_\_\_\_\_
- YES NO** 20. Have you ever had a back injury?    Date and type: \_\_\_\_\_
- YES NO** 21. Have you ever had a back surgery?    Date and type: \_\_\_\_\_
- YES NO** 22. Have you ever had a hip/pelvis injury?    Date and type: \_\_\_\_\_
- YES NO** 23. Have you ever had hip/pelvis surgery?    Date and type: \_\_\_\_\_
- YES NO** 24. Have you ever had a knee injury?    Date and type: \_\_\_\_\_
- YES NO** 25. Have you ever had knee surgery?    Date and type: \_\_\_\_\_
- YES NO** 26. Have you ever had a lower leg injury?    Date and type: \_\_\_\_\_
- YES NO** 27. Have you ever had an ankle injury?    Date and type: \_\_\_\_\_
- YES NO** 28. Have you ever had ankle surgery?    Date and type: \_\_\_\_\_
- YES NO** 29. Have you ever had an injury to your elbow, wrist, hand, or foot?

Date and type: \_\_\_\_\_

- YES NO** 30. Do you have a metal implant in your body (pin, plate, screw, etc.)? Where: \_\_\_\_\_
- YES NO** 31. Are you happy with your weight?
- YES NO** 32. Are you trying to loss or gain weight (indicate which one)?
- YES NO** 33. Has anyone recommended you change your weight or eating habits?
- YES NO** 34. Do you limit or carefully control what you eat?
- YES NO** 35. At any time during the school year do you practice the act of fasting for personal and/or religious reasons?
- YES NO** 36. Have you ever been diagnosed with Marfan's Syndrome?
- YES NO** 37. Have you ever been diagnosed with a bleeding disorder? Which one: \_\_\_\_\_
- YES NO** 38. Have you ever had a menstrual period?
- YES NO** 39. How old were you when you had your first menstrual period? \_\_\_\_\_
- YES NO** 40. How many periods have you had in the last 12 months? \_\_\_\_\_
- YES NO** 41. Have you ever been told by medical personnel that you should not participate in sports? When and why: \_\_\_\_\_
- YES NO** 42. Do you have any other medical conditions/concerns not already addressed on this form? List and explain: \_\_\_\_\_
- \_\_\_\_\_

I hereby certify the answers to these questions are correct and true. I understand that Simmons College cannot be held responsible for any previous medical conditions. I understand that this medical history form is for no other purpose than to clear me for athletic participation at Simmons College.

**Student-Athlete Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(if athlete is under 18)

**Athletic Trainer Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Please return to: **Alicia Roane**  
**Head Athletic Trainer**  
**Simmons College**  
**300 The Fenway**  
**Boston, MA 02115**