

Are you allergic to any medications? _____ Yes _____ No _____
If yes please indicate: _____

Currently taking any Medication? _____ Yes _____ No _____
If yes please indicate: _____

Do you currently have asthma? Yes _____ No _____
If yes, please list any medication that you are taking and the date of your last asthma attack: _____

Please indicate if you have or are suffering from any of the following injuries or illnesses. If you have had any of the following problems please indicate date, left or right, and if treated by a physician.

Head and Neck Injuries

- | | | |
|-----|----|--|
| Yes | No | 1. Have you ever had a concussion? When _____ Were you completely unconscious? YES NO How many concussions have you had? _____ |
| Yes | No | 2. Do you have a history of headaches? Do they require prescription medications? YES NO
If yes please list medication name _____ |
| Yes | No | 3. Have you ever injured your neck? Describe the injury _____
Were you seen by a physician? YES NO Were you hospitalized? YES NO |
| Yes | No | 4. Have you ever had a "stinger" or "burner" in your neck or shoulders?
Left Right Both Date(s) |
| Yes | No | 5. Have you ever had an injury involving the vertebral discs in your neck?
Date(s) _____ Treating Physician _____ |
| Yes | No | 6. Have you ever had a mouth injury? What type of injury? _____
Were you seen by a physician? YES NO Have you had mouth surgery? YES NO |
| Yes | No | 7. When was your last eye examination? _____ Were there any visual problems found?
YES NO If yes, please describe. _____ |
| Yes | No | 8. Do you have a hearing impairment? Left Right |
| Yes | No | 9. Do you have any dental appliances? Braces Permanent Bridge Crown
Partial Caps False Teeth Full Plate (Please circle all that apply) |

Upper Extremities

- | | | |
|-----|----|---|
| Yes | No | 1. Have you ever separated, dislocated, or had any shoulder injuries? Left Right
Please describe with dates: _____ |
| Yes | No | 2. Have you ever had shoulder surgery? Please describe with dates: _____ |

Were you released to participate in athletics? YES NO If yes, by whom (please indicate physicians name and phone number) _____

Yes No 3. Have you ever sprained, strained, fractured, dislocated or otherwise injured your elbow?
Left Right Describe and give dates: _____

Yes No 4. Have you ever sprained, strained, fractured, dislocated or otherwise injured your wrist?
Left Right Describe and give dates: _____

Yes No 5. Have you ever jammed, dislocated, or fractured any bones of your hands or fingers?
Left Right Describe and give dates: _____

Upper and Lower Back

Yes No 1. Have you ever injured your back? Describe and give dates: _____

Yes No 2. Were you treated for this back injury? Did you see a physician? YES NO
Did you see a chiropractor? YES NO Dates: _____

Yes No 3. Do you experience pain in your back after exercise or lifting? How often does this pain occur?

Lower Extremities

Yes No 1. Have you ever injured either hip? Left Right Describe and give dates: _____

Yes No 2. Have you ever pulled/strained either hamstring? Left Right How many times? _____

Yes No 3. Have you ever injured the meniscus or cartilage in either knee? Left Right
Describe and give dates: _____

Yes No 4. Have you ever injured any ligaments in either knee? Left Right Describe and give dates of
injury: _____

Yes No 5. If you answered YES to either # 3 or #4, were you seen by a physician? Did they advise
surgery? YES NO If yes, give dates of surgery: _____
Were you released to participate in athletics? YES NO Give date: _____

Yes No 6. Have you ever had any tendonitis? Left Right Were you seen a physician? YES NO
Dates: _____ Were you released by a physician? YES NO Date: _____

Yes No 7. Have you had any other problems with your knees or surrounding structures? Describe and
Give dates: _____

Yes No 8. Have you ever had shin splints or stress fractures in the lower leg? If yes, do they occur often?
YES NO _____

Yes No 9. Have you ever experienced an ankle sprain on either ankle? Left Right Date(s) _____
Did this restrict your athletic participation? YES NO

Yes No 10. Have you had any other type of injury to either ankle? Left Right Describe and give
date(s): _____

Yes No 11. Have you ever had an injury to either foot? Left Right Describe and give date(s): _____

Yes No 12. Do you wear custom made orthotics?

Heat Related Illnesses

- Yes No 1. Have you ever passed out during or after exercise? If yes, when _____
- Yes No 2. Have you ever been dizzy during or after exercise? If yes, when _____
- Yes No 3. Have you ever had chest pain during or after exercise? If yes, when _____
- Yes No 4. Do you tire more quickly than your friends during exercise?
- Yes No 5. Have you ever had high blood pressure?
- Yes No 6. Have you ever been told you have a heart murmur? If yes, explain _____

- Yes No 7. Have you ever had a racing pulse, or your heart skipped beats? If yes, explain _____

- Yes No 8. Has anyone in your family died of heart problems or a sudden death before age 50? If yes, who and at what age? _____
- Yes No 9. Have you ever had heat or muscle cramps?
- Yes No 10. Have you ever been dizzy or passed out in the heat? If yes, when? _____
- Yes No 11. Have you ever experienced heat cramps, heat exhaustion, or heat stroke? Please circle, describe and give dates including location of occurrence and if hospitalization was required. If yes, explain. _____

General Medical

- Yes No 1. Do you have any skin problems? If yes, explain. _____
- Yes No 2. Do you have trouble breathing or do you cough during or after activity?
- Yes No 3. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guard, etc.)?
- Yes No 4. Have you had any problems with your eyes or vision?
- Yes No 5. Do you wear glasses or contacts or protective eyewear?
- Yes No 6. When was your last tetanus shot? _____
- Yes No 7. When was your last measles immunization? _____
- Yes No 8. Have you had any other operation in the past three years? If yes, describe and give dates _____

- Yes No 9. Have you ever been advised by a physician not to participate in any form of athletics, on a permanent basis? Please describe and give dates? _____

- Yes No 10. Have you had any additional illnesses or injuries during the past three years? Describe and give date(s) _____

Yes No 11. Is there any health or medical related problems that you feel needs to be disclosed in order to provide the best medical care possible? Please describe: _____

Female Student-Athletes (Males skip this section)

Yes No 1. Does your menstrual cycle occur: (monthly, twice monthly, other). Please circle, please specify any irregularities. _____

Yes No 2. Have you ever missed more than three consecutive menstrual periods at any time?

Yes No 3. Have you ever missed your menstrual period for six consecutive months? Number of months missed? _____

Yes No 4. Are you currently using any type of birth control? If yes, what kind? _____

Yes No 5. Have you ever had a breast examination? Date of last examination _____

Yes No 6. Have you had a PAP smear? Date of last examination _____

Yes No 7. Has a physician ever diagnosed you with anorexia nervosa or bulimia?

Please read and sign the following statement

I certify that all of the above information is accurate and current, and hereby authorize the appropriate Spartanburg Methodist College personnel to provide and seek proper medical care in the event I am injured or require medical treatment while participating in Spartanburg Methodist College Athletics.

Athletes Name

Signature

Date

Parent Signature (if under 18)

Date

Reviewing Certified Athletic Trainer/
SMC Medical Personnel

Date

SPARTANBURG METHODIST COLLEGE
ATHLETIC TRAINING
Athletic Participation General Physical Exam

Social Security #: _____ Name: _____

Date: _____ Freshman: _____ Sophomore: _____

Blood Pressure: _____ Pulse: _____ Ht: _____ Wt: _____

	Check if Normal	Abnormal Findings
General Appearance		
Eyes		
Ears, Nose, Throat		
Lymph Nodes		
Heart		
Chest and Lungs		
Abdomen		
Skin		
Genitalia (Males Only)		
Femoral Pulse		
Marfan's Screen		

Comments: _____

Clearance:

{ } Cleared

{ } Prior to participation, athlete requires: _____

{ } Not Cleared

Physician Signature: _____

Date; _____

SPARTANBURG METHODIST COLLEGE
 ATHLETIC TRAINING ROOM
 Athletic Participation Orthopedic Physical Exam

Social Security # _____ Name: _____
 Date: _____ Freshman: _____ Sophomore: _____

Body Part			Right	Right	Left	Left	Comments
			N	AB	N	AB	
Spine	Cervical						
	Thoracic						
	Lumbar						
Shoulder	ROM						
	Rotator Cuff	Impingement					
		Supraspinatus					
	Palpation	A/C Joint					
		Biceps Tendon					
		Ant. Capsule					
		A/P Capsule					
		Instability	A/P Multi Relocation				
Elbow	ROM						
	Strength						
Wrist/Hand	ROM						
	Strength						
Fingers	ROM						
	Instability						
Hip	ROM						
	Strength						
Knee	ROM						
	Strength						
	Instability						
Ankle	ROM						
	Strength						
	Instability						
Foot/Toes							

Comments: _____

Clearance:
 { } Cleared
 { } Prior to participation, athlete requires: _____
 { } Not cleared

Physician Signature: _____ Date: _____