Participant Name: _____ Sport:_____

Smith College Athletic Training Services- Medical History Questionnaire (FORM 3)

Part 1: Student-Athlete Information

Campus Phone (room or cell):_____ Date of Last Physical (month/year): _____ Grad Yr:_____

Height (Ft/In):_____ Weight (pounds):_____ Date of Birth: _____ ___Minor ___Adult

Part 2: Cardiovascular Screening Questionnaire

1. Have you ever been diagnosed with a heart murmur?	___Yes ___No
2. Do you have a personal history of high blood pressure?	___Yes ___No
3. Do you have a personal history of elevated cholesterol?	___Yes ___No
4. Do you have a family history of diabetes?	___Yes ___No
5. Do you have a personal or family history of Marfan's Syndrome?	___Yes ___No
6. Do you have a family history of heart disease?	___Yes ___No
7. Do you have a family history of sudden death under the age of 50 from non-traumatic causes?	___Yes ___No
8. Do you currently take medications for blood pressure or a heart condition?	___Yes ___No
9. Have you ever been restricted from activity by a physician because of a heart condition?	___Yes ___No
10. Do you feel pain in your chest, wheezing, coughing or dizziness when you do physical activity?	___Yes ___No
11. Do you ever feel strange beats (palpitations) in your chest when you are doing physical activity?	___Yes ___No
* If "yes" do they continue after you have rested? ___Yes ___No	
12. In the past month, have you had chest pain when you were not doing physical activity?	___Yes ___No
13. Do you ever lose your balance because of dizziness or do you ever lose consciousness (pass-out)?	___Yes ___No
14. In the past year, have you had any medical tests for your heart? (ex. Ultrasound, EKG, echocardiogram)	___Yes ___No

Part 3: Medical Conditions

15. Please check "yes" if you currently have or have had in the past 3 years any of the following:

a. Serious illness (hospitalization)	___Yes ___No	e. Asthma	___Yes ___No
b. Surgery	___Yes ___No	f. Heat Illness	___Yes ___No
c. Diabetes	___Yes ___No	g. Seizure Disorder	___Yes ___No
d. Bleeding Disorder	___Yes ___No	h. Chronic Illness (including mental illness)	___Yes ___No

16. Have you ever had a concussion or been "knocked out"? ___Yes ___No
If yes, how many times?

17. Have you ever had a loss of or problem with a paired organ? (kidney, eye, ear) ___Yes ___No

18. Do you have any allergies? (Include medicines, environmental, foods, insects, latex, etc) ___Yes ___No

Have you ever been told that you should carry an epi-pen? ___Yes ___No

19. Have you had a serious injury to bones, muscles or joints in the past 3 years which required medical attention? ___Yes ___No

20. Has a physician ever recommended that you do not participate in athletics? ___Yes ___No

**Please provide as much detail as possible for any "YES" responses in the space below. Indicate the # of the question for which you are providing details. Please include dates, medical tests, treatments, current status and if your physician has granted you clearance for athletics:

_____
_____
_____
_____
_____
_____
_____
_____

My signature below indicates that I have completed this form truthfully and to the best of my knowledge.

_____ _____ _____ _____
Signature Date Signature of parent/guardian if under 18 Date

For Athletic Training Staff Only

Recommendation: ____Must have physical exam for:_____ ____Must provide documentation of clearance from:_____

Precautions: _____Inhaler _____Epi-pen ____Protective Device:_____ _____Head Injury ____Rehab Program for:_____

Reviewed on:_____ **ATC Initials:_____**