

San Jose Stealth  
Team

Player's Name

Evaluation Date

Season 2006



# Pre-participation Medical Evaluation

## ***Evaluation Checklist***

- \_\_\_\_\_ Medical History
- \_\_\_\_\_ Orthopedic History
- \_\_\_\_\_ Medical Evaluation
- \_\_\_\_\_ Orthopedic Evaluation
- \_\_\_\_\_ Other

## **Completed Medical Evaluation Status**

*Based on the following comprehensive medical evaluation, this player is:*

- \_\_\_\_\_ Cleared without restrictions
- \_\_\_\_\_ Cleared with the following restrictions: \_\_\_\_\_
- \_\_\_\_\_ Cleared, pending these results/tests: \_\_\_\_\_
- \_\_\_\_\_ Denied clearance due to: \_\_\_\_\_

Team Physician Name (print)

Team Physician Signature and Date

Team: San Jose Stealth

Date: \_\_\_\_\_

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### Player Demographics

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

SS#: \_\_\_\_\_ Date of Birth: (Day, Month, Year) \_\_\_\_\_

Current Address: \_\_\_\_\_ Local Phone: \_\_\_\_\_

\_\_\_\_\_ Mobile Phone: \_\_\_\_\_

\_\_\_\_\_ Pager: \_\_\_\_\_

Permanent Address: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_ Other Contact # \_\_\_\_\_

\_\_\_\_\_ (cell, pager, etc.)

### Emergency Contact Information

*Emergency Contact #1*

Name: \_\_\_\_\_

Relation: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone #'s: \_\_\_\_\_

*Emergency Contact #2*

Name: \_\_\_\_\_

Relation: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone #'s: \_\_\_\_\_

### Personal Information

*Personal Physician:*

Name: \_\_\_\_\_

Phone #'s: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Marital Status:  Single  Married  Divorced (circle one)

Wife's or Girlfriend Name: \_\_\_\_\_

Children (Name(s) & Age) \_\_\_\_\_

Off-season Occupation/Activities: \_\_\_\_\_

Position \_\_\_\_\_

NLL Rookie    NLL Veteran (circle one)

Years in NLL \_\_\_\_\_

List all prior sports teams and dates of play. Begin with the most recent and include professional, semi-professional, and collegiate play.

If you incurred an injury resulting in time lost from practices or games, please provide further information. List all injuries separately.

	<b>TEAM</b>	<b>CITY/STATE</b>	<b>DATES OF PLAY</b>	<b>INJURY DESCRIPTION</b>	<b>DATE OF INJURY</b>	<b>TREATING PHYSICIAN</b>
Ex	<i>Univ. of Lacrosse</i>	<i>OKC / OK</i>	<i>Fall 94-Spring 98</i>	<i>Right ankle sprain</i>	<i>Fall 1998</i>	<i>Dr. Seuss</i>
1						
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12						
13						
14						
15						

## Medical History

Answer each question by checking the appropriate YES or NO box. Yes answers require that you give a full explanation when requested by the evaluating physician.

HAVE YOU EVER EXPERIENCED OR ARE YOU CURRENTLY EXPERIENCING: (check each item)

	Y	N	Comments
Scarlet Fever			
Rheumatic Fever			
Heart Murmur			
Heart Trouble			
High blood pressure or low blood pressure			
Mumps			
Chicken pox			
Measles			
Frequent or severe headaches			
Dizziness or fainting spells or near faints			
Chest pain			
Palpitation or skipped heart beats			
Eye, ear, nose or throat trouble			
Tonsillitis			
Severe tooth or gum trouble			
Sinusitis			
Allergies			
Tuberculosis			
Coughed up blood			
Pneumonia			
Asthma			
Chronic cough			
Stomach, intestinal trouble (ulcer)			
Gall bladder trouble, gallstones			
Do you smoke?			
Do you use smokeless tobacco (chew)?			
Do you drink alcohol?			( if yes, how much and often)
Do you (or have you ever) used any narcotics or street drugs			
Tumor, growth, cyst, cancer			
Appendicitis			
Hernia			

	Y	N	Comments
Piles or rectal disease			
Frequent or painful urination			
Kidney stone, bloody urine			
Skin trouble			
Venereal disease			
Bone, joint or other deformity			
Epilepsy or fits			
Car, train, sea, air sickness			
Depression, anxiety or excessive worry			
Loss of memory or amnesia			
Gout			
Do you use any prescription medication?			
Do you use any non-prescription medication?			
Do you use nutritional supplements, herbal products or "alternative" medications?			

**Family History:** If you or your immediate family (mother, father, brother, sister) have had any of the following illnesses or problems, please check yes.

	Y	N	Comments
Diabetes			
Allergies			
Arthritis			
Goiter			
Cancer			
Obesity			
Neurological disorders			
Gout			
Heart disease			
High blood pressure			
Sudden death (specifically, family member under 50)			
Blood disorders or easy bleeding			
Kidney disease			
Mental illness			
Tuberculosis			
Sickle cell anemia			
Problems with the use of anesthesia			

Read and answer the following questions carefully. If you answer yes to any questions, you must explain them fully to the evaluating physician.

	Y	N	Comments
Have you ever been treated for Infectious Mononucleosis, Viral Pneumonia, or any other infectious disease in the last 12 months?			
Have you ever been treated for diabetes?			
If so, do you take medication?			
Have you ever had an allergic reaction to drugs? (Penicillin?)			
Have you ever been "knocked out" or experienced a concussion?			
If so, how many concussions have you had in HS? ____ College? ____ After College? ____			
If so, did you have to stay overnight in a hospital?			
Have you ever had a "burner" or "stinger"			
Have you ever been treated for calcium deposits? Where?			
How often do you experience back pain? Never			
Occasionally			
Frequently			
Only after exercise or heavy lifting			
Do you have a pin, screw or plate somewhere in your body as a result of bone or joint surgery?			
Have you ever had a bone graft or a spinal fusion?			
Have you had a fracture during the past 2 years?			
Have you had an operation during the past 2 years?			
Have you ever been told you have a hernia?			
Have you had any additional illness, injuries, or operations? (other than childhood diseases)			
Are you presently under a physicians care for any problem not already discussed?			
Have you ever, or are you presently using any habit forming drugs?			
Have you every had a hearing problem or worn hearing aids?			
Have you ever bled excessively after having a tooth removed?			
Have you ever been advised to have an operation not yet performed?			
Have you ever sustained an eye injury?			
Do you wear eye glasses?			
Do you wear contact lenses? If yes, hard or soft lenses			
Do you wear them during athletic participation?			
What is the date of your last tetanus shot?			

## Orthopedic History

Answer each question by checking the appropriate YES or NO box. Yes answers require that you give a full explanation when requested by the evaluating physician.

HAVE YOU EVER SUSTAINED AN INJURY TO YOUR: (check each item)

	Y	N	Comments
Head/Face			
Neck			
Abdomen			
Back			
Chest and Ribs			
Pelvis			

		Right		Left			Comments
		Y	N	Y	N		
Shoulder							
Upper Arm							
Elbow							
Forearm							
Wrist							
Hand							
Finger	thumb						
	index						
	middle						
	ring						
	little						
Hip							
Groin							
Thigh							
Hamstring							
Knee							
Lower Leg							
Ankle							
Foot							
Big Toe							
Other Toes							

Please list all orthopedic operations (arthroscopic or any surgery to repair a joint, bone, muscle or tendon).

Please provide body part treated by surgery, dates and treating physician if possible.

1	5
2	6
3	7
4	8

## Medical Evaluation

*The Physician will complete this section*

Date: \_\_\_\_\_

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

B/P: \_\_\_\_ / \_\_\_\_

Pulse: \_\_\_\_\_

	N	AB	Comments
Head/Face			
Eyes - Acuity			
- Movements			
- Fields			
- Nystagmus			
- Pupils			
- Fundi & Discs			
- Depth Perception			
Ears			
Nose			
Mouth/Throat - Tonsils			
Neck - Nodes			
- Thyroid			
Respiratory - Upper			
- Lower			
Cardiovascular - Rhythm			
- Sounds			
- Murmurs			
- Pulse			
- Varicosites			
Abdomen			
Genito Urinary - Testicles			
- Hernia			
If Indicated: - Rectal			
Skin			
Neurological Findings			Note concussion hx

*Based on the preceding medical evaluation, this player is:*

- Cleared without medical restrictions
- Cleared with the following medical restrictions: \_\_\_\_\_
- Cleared pending these results/tests: \_\_\_\_\_
- Denied clearance due to: \_\_\_\_\_

\_\_\_\_\_  
Evaluating Physician (print)

\_\_\_\_\_  
Evaluating Physician (Signature and Date)

## Orthopedic Evaluation

Date: \_\_\_\_\_

	N	AB	Comments
<b>Spine/Thorax</b>			
Cervical			
Thoracic			
Lumbar			
Chest/Ribs			

	Right		Left		Comments
	N	AB	N	AB	
<b>Shoulder</b>					
- R.O.M.					
- Sternoclavicular					
- Clavicle					
- Acromioclavicular					
- Scapula					
- Glenohumeral					
- Apprehension Test					
- Rotator Cuff					
- Bursa					
<b>Upper Arm</b>					
<b>Elbow</b>					
- R.O.M.					
- M. Epicondyle					
- L. Epicondyle					
- Olecranon Bursa					
- Radial Head					
<b>Forearm</b>					
<b>Wrist</b>					
<b>Hand and Fingers</b>					
<b>Thumb</b>					
<b>Pelvis</b>					
- Sacroiliac					
- Pubis					
- Adb. Muscles					
- Groin					
- Hip Joint					
- Other					
<b>Thigh</b>					
- Quadriceps					
- Hamstring					
- Femur					

	Right		Left		Comments
	N	AB	N	AB	
<b>Knee</b>					
- R.O.M.					
- Effusion					
- Lachman					
- Ant. Drawer					
- Post. Drawer					
- Pivot Shift					
- Valgus Stress					
- Varus Stress					
- McMurray Test					
- Joint Line Tenderness					
- Crepitus					
- Patella					
Lat. Apprehension					
Tenderness					
Q-Angle					
Patella Crepitus					
- Popliteal Fossa					
<b>Lower Leg</b>					
- Tibia and Fibula					
- Ant. Compartment					
- Post. Compartment					
- Tendo Achilles					
<b>Ankle</b>					
- R.O.M.					
- Med/Lat Malleolus					
- Ant. Drawer					
<b>Foot</b>					
- Midfoot					
- Med. Long Arch					
<b>Toes</b>					
- Great Toe/Sesamoid					
- Other Toes					

Based on the preceding orthopedic evaluation, this player is:

- Cleared without orthopedic restrictions
- Cleared with the following ortho restrictions: \_\_\_\_\_
- Cleared pending these results/tests: \_\_\_\_\_
- Denied orthopedic clearance due to: \_\_\_\_\_

\_\_\_\_\_  
Evaluating Physician (print)

\_\_\_\_\_  
Evaluating Physician (Signature and Date)

## Certification

I certify that I have answered this questionnaire and all questions of the team physician completely and correctly to the best of my knowledge. I certify that I have not had any prior illness or injuries other than those I have listed on this questionnaire.

I further certify that the team physician has explained to me that playing professional lacrosse may result in serious physical injury and in the aggravation, deterioration, or reinjury of any preexisting medical condition(s) during and after my employment by the San Jose Stealth. I fully understand and assume the possible consequences of playing professional lacrosse with the medical condition(s) set forth in this questionnaire or discussed with the team physician.

## Release

I understand that the team physician is a representative of the San Jose Stealth and that he or she may therefore disclose any or all of the medical information contained in this questionnaire and evaluation or my medical files to the team in determining my ability to play professional lacrosse. I further authorize the release to the team and its coaching staff of all medical and surgical information gained by the team physician during the time I am a player for the above named team.

I hereby authorize the team to release this questionnaire and any and all other information in my medical file to any other team to which I am released, or traded, or to which my contract is assigned.

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(If applicable) I have reviewed my medical summary that was updated on

and:

\_\_\_\_\_ Date/Month/Year

- I certify that it is complete, accurate, and up-to-date, I have had no additional injury, illness, or surgery performed.
- Please make the following additions or corrections to update my medical summary:

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Date: \_\_\_\_\_

\_\_\_\_\_  
Players Signature

\_\_\_\_\_  
Medical Staff Representative

## NLL Evaluation Follow-Up / Summation

Players Name: \_\_\_\_\_

Position: \_\_\_\_\_

Date: \_\_\_\_\_

**Inactive Problems:**

**Allergies:**

**Medical Conditions:**

**Active Problems:**

**Notes:**