



MEDICAL FORM TEMPLATE FOR MHA'S

To be completed by the athlete

Last Name _____ First Name _____

Address _____ City _____ Province _____

Date of Birth _____ Home Phone # (_____) _____ Postal Code _____
Day Month Year

Health Care # _____ Province _____

FOR EMERGENCY NOTIFY: Name _____ Relationship _____

Address _____ Phone _____

Family Doctor's Name _____ Date of Last Physical _____
Month Year

Sport: _____

Year of Participation in Sport (circle): 1st 2nd 3rd 4th 5th 6th

Year of Participation in Hockey (circle): 1st 2nd 3rd 4th 5th 6th

What position will you be playing this year? _____

Explain "Yes" answers below:

	Yes	No
1. Have you ever been hospitalized?.....	0	0
Have you ever had surgery?.....	0	0
2. Are you presently taking any medications or pills?.....	0	0
Are you presently taking any vitamins or supplements?.....	0	0
3. Do you have any allergies (medicine, bees or other stinging insects)?.....	0	0
4. Have you ever passed out during or after exercise?.....	0	0
Have you ever been dizzy during or after exercise?.....	0	0
Have you ever had chest pain during or after exercise?.....	0	0
Do you tire more quickly than your friends during exercise?.....	0	0
Have you ever had high blood pressure?.....	0	0
Have you ever been told that you have a heart murmur?.....	0	0
Have you ever had racing of your heart or skipped heartbeats?.....	0	0
Has anyone in your family died of heart problems or a sudden death before age 50?.....	0	0
5. Do you have any skin problems (itching, rashes, acne)?.....	0	0
6. Have you ever had heat or muscle cramps?.....	0	0
Have you ever been dizzy or passed out in the heat?.....	0	0
7. Do you have trouble breathing or do you cough during or after activity?.....	0	0
8. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)?.....	0	0
Do you use any dental appliances?.....	0	0
9. Have you had any problems with your eyes or vision?.....	0	0
Do you wear glasses or contacts or protective eye wear?.....	0	0
10. Have you had any other medical problems (Infectious mononucleosis, diabetes, etc.)?.....	0	0
11. Have you had a medical problem or injury since your last evaluation?.....	0	0
12. Have you had any unexplained weight change?.....	0	0
13. When was your last tetanus shot? _____		
When was your last measles immunization? _____		

14. Female Athletes: Over the past year, did your periods occur about once a month?..... 0 0

Explain "Yes" answers

(Over ?)

HEAD INJURIES / CONCUSSIONS:

- | | Yes | No |
|---|-----|----|
| 15. Have you ever had a seizure?..... | o | o |
| 16. Have you ever had a head injury? | o | o |
| Have you ever had a concussion or been "knocked out", had your "bell rung", or been "dinged"? | o | o |

If YES, please list: Number: _____

<u>Date(s)</u> <u>activity</u>	<u>Activity at the time</u>	<u>Length of unconsciousness (minutes)</u>	<u>Length of time before full return to</u>
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Did you have any persistent problems with:
memory YES NO dizziness YES NO headaches YES NO

NECK INJURIES / BURNERS / STINGERS:

- | | Yes | No |
|---|-----|----|
| 17. Have you ever had a neck injury (ie, strain, sprain, fracture, etc.)..... | o | o |
| 18. Have you ever had a stinger, burner or pinched nerve?..... | o | o |
- (a burning or numb feeling in the shoulder or arm after a hit to the head, neck or shoulder - aka. "brachial plexus stretch injury")

If YES, please list: Number: _____

<u>Date(s)</u>	<u>Activity at the time</u>	<u>Length of time sensation/strength changes persisted?</u>
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19. Check any of the areas that you have INJURED IN THE PAST and explain the injury below:

Hand _____	Elbow _____	Neck _____	Hip _____	Shin/Calf _____
Wrist _____	Arm _____	Chest _____	Thigh _____	Ankle _____
Forearm _____	Shoulder _____	Back _____	Knee _____	Foot _____

<u>Year of injury</u>	<u>Type of injury</u>	<u>Side (right, left, both)</u>	<u>Is it still a problem? (Yes/No)</u>
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- | | Yes | No |
|--|-----|----|
| 20. Do you have any incompletely healed injury?..... | o | o |

If yes, which injury? _____

I hereby certify the above information to be correct.

Athlete Signature _____ Date _____

Parent/Guardian Signature _____ Date _____