



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 ?)