# 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? | o | o |
| Have you ever had surgery? | o | o |
| 2. Are you presently taking any medications or pills? | o | o |
| Are you presently taking any vitamins or supplements? | o | o |
| 3. Do you have any allergies (medicine, bees or other stinging insects)? | o | o |
| 4. Have you ever passed out during or after exercise? | o | o |
| Have you ever been dizzy during or after exercise? | o | o |
| Have you ever had chest pain during or after exercise? | o | o |
| Do you tire more quickly than your friends during exercise? | o | o |
| Have you ever had high blood pressure? | o | o |
| Have you ever been told that you have a heart murmer? | o | o |
| Have you ever had racing of your heart or skipped heartbeats? | o | o |
| Has anyone in your family died of heart problems or a sudden death before age 50? | o | o |
| 5. Do you have any skin problems (itching, rashes, acne)? | o | o |
| 6. Have you ever had heat or muscle cramps? | o | o |
| Have you ever been dizzy or passed out in the heat? | o | o |
| 7. Do you have trouble breathing or do you cough during or after activity? | o | o |
| 8. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)? | o | o |
| Do you use any dental appliances? | o | o |
| 9. Have you had any problems with your eyes or vision? | o | o |
| Do you wear glasses or contacts or protective eye wear? | o | o |
| 10. Have you had any other medical problems (infectious mononucleosis, diabetes, etc.)? | o | o |
| 11. Have you had a medical problem or injury since your last evaluation? | o | o |
| 12. Have you had any unexplained weight change? | o | o |
| 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? | o | o |

in "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: _____

| Date(s) activity | Activity at the time | Length of unconsciousness (minutes) | Length of time before full return to |
|---|---|---|---|
| | | | |

Did you have any persistent problems with:
memory YES NO dizziness YES NO headaches YES NO

**NEDK 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: _____

| Date(s) | Activity at the time | Length of time sensation/strength changes persisted? |
|---|---|---|
| | | |

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 ___ |

| Year of injury | Type of Injury | Side (right, left, both) | Is it still a problem? (Yes/No) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| | 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 _____