



# 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      5<sup>th</sup>      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? .....  | 0   | 0  |
| 16. Have you ever had a head injury? .....  | 0   | 0  |
| Have you ever had a concussion or been "knocked out", had your "bell rung", or been "dinged"? ..... | 0   | 0  |

If YES, please list:          Number: \_\_\_\_\_

<u>Date(s)</u> <u>activity</u>	<u>Activity at the time</u>	<u>Length of unconsciousness</u> (minutes)	<u>Length of time before full return to</u> <u>activity</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.) ..... | 0   | 0  |
| 18. Have you ever had a stinger, burner or pinched nerve? .....                | 0   | 0  |
- (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? ..... | 0   | 0  |

If yes, which injury? \_\_\_\_\_

*I hereby certify the above information to be correct.*

Athlete Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_