Athlete Medical History Form

Last Name _____ First Name _____

Position _____ Date of Birth (DD/MM/YYYY)_____

Health Care # _____(Optional) Province _____

Local Phone # _____ Off Season Phone # _____

Local Address_____

Emergency Contact Information

Name _____ Relationship _____

Phone # _____ City _____

Family Doctor _____ Dr. Phone # _____

Medical History

Alcohol habit	YES	NO	Intestinal disorder	YES	NO
Anemia	YES	NO	Jaundice	YES	NO
Appendicitis	YES	NO	Kidney disease	YES	NO
Asthma	YES	NO	Bloody urine	YES	NO
Blood disorder	YES	NO	Malfunctioning organs	YES	NO
Cancer	YES	NO	Missing organs	YES	NO
Cyst, tumor or growth	YES	NO	Memory loss	YES	NO
Calcium deposits	YES	NO	Motion sickness	YES	NO
Chest pain or pressure	YES	NO	Mononucleosis	YES	NO
Childhood disease (measles)	YES	NO	Neurological disorder	YES	NO
Collapsed lung	YES	NO	Pneumonia	YES	NO
Coughed up blood	YES	NO	Recurrent headaches	YES	NO
Diabetes	YES	NO	Recurrent nose bleeds	YES	NO
Dizziness or fainting	YES	NO	Rheumatic fever	YES	NO
Epilepsy	YES	NO	Sexually transmitted disease	YES	NO
Excessive bleeding	YES	NO	Shortness of breath	YES	NO
Gout	YES	NO	Sinusitis	YES	NO
Ear pain	YES	NO	Sickle cell anemia	YES	NO
Hearing problems	YES	NO	Skin rash, infection, hives	YES	NO
Hearing aid	YES	NO	Severe dental or gum issue	YES	NO
Heart disease	YES	NO	Smoking habit	YES	NO
Heart murmur	YES	NO	Stomach ulcer	YES	NO
Irregular heartbeat	YES	NO	Stroke	YES	NO
Heat stroke/exhaustion	YES	NO	Sudden death before 50	YES	NO
Hernia	YES	NO	Surgery/hospitalization	YES	NO
Hepatitis	YES	NO	Tonsillitis	YES	NO
High or low blood pressure	YES	NO	Tuberculosis	YES	NO
High blood cholesterol	YES	NO	Vision problem	YES	NO

Medical History: Please provide a brief explanation for any of the above YES answers.

_____

_____

Allergies: List any allergies you have and describe your reaction.

_____

_____

Medications: List any prescription or non-prescription medications, vitamins or supplements.

_____

_____

Physical Examination: Date of last physical exam by a medical doctor and results/findings.

_____

_____

Do you wear glasses or contacts for sports?	YES	NO
Do you wear a visor for football?	YES	NO
Wear false teeth, braces, plate or dental appliances?	YES	NO
Have you ever been advised not to participate in sports?	YES	NO
Do you have any surgical pins, screws or plates in your body?	YES	NO
Have you been advised to have surgery but it has not occurred?	YES	NO

Head Injury History: List any previous head injuries (concussions), date and severity.

_____

_____

Musculoskeletal Injury History: List any musculoskeletal injuries and if they are still a problem.

_____

_____

Additional Information: including other medical concerns the trainers should be aware of.

_____

_____

_____

_____

I understand that it is my responsibility to keep the team Safety Person advised of any change in the above information as soon as possible. In the event of a medical emergency and that no one can be contacted, team management will arrange to take my child to the hospital or a physician if deemed necessary. I hereby authorize the physician and nursing staff to undertake examination, investigation and necessary treatment of my child. I also authorize release of information to appropriate people (coach, physician) as deemed necessary.

Date: _____ Signature of Player:

_____

Date: _____ Signature of Parent or Guardian:

_____