

# ATHLETE MEDICAL HISTORY FORM

PATIENT'S SURNAME \_\_\_\_\_

PATIENT'S GIVEN NAME \_\_\_\_\_

ADDRESS: \_\_\_\_\_

MALE

FEMALE

DATE OF BIRTH (M/D/Y): \_\_\_\_\_

SPORT/EVENT \_\_\_\_\_

DATE OF LAST TETANUS BOOSTER: \_\_\_\_\_

COACH/MANAGER \_\_\_\_\_

BLOOD GROUP & TYPE: \_\_\_\_\_

CORRECT PROVINCIAL MEDICARE NUMBER MUST BE PROVIDED:

HEIGHT: \_\_\_\_\_

MEDICAL INSURANCE No. \_\_\_\_\_

WEIGHT: \_\_\_\_\_

FAMILY PHYSICIAN: \_\_\_\_\_ PHONE (DAY): \_\_\_\_\_ (NIGHT): \_\_\_\_\_

NEXT OF KIN: \_\_\_\_\_ PHONE (DAY): \_\_\_\_\_ (NIGHT): \_\_\_\_\_

IN CASE OF EMERGENCY PLEASE NOTIFY: \_\_\_\_\_ PHONE (DAY): \_\_\_\_\_ (NIGHT): \_\_\_\_\_

## OUTLINE PAST HISTORY OR ILLNESS

HAVE YOU EVER HAD OR DO YOU NOW HAVE:

	YES	NO
HEAD INJURY	<input type="checkbox"/>	<input type="checkbox"/>
SEIZURES	<input type="checkbox"/>	<input type="checkbox"/>
NECK/BACK DISORDER	<input type="checkbox"/>	<input type="checkbox"/>
FAINTING SPELLS	<input type="checkbox"/>	<input type="checkbox"/>
PSYCHIATRIC DISORDER	<input type="checkbox"/>	<input type="checkbox"/>

EYE PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
GLASSES/CONTACTS	<input type="checkbox"/>	<input type="checkbox"/>
NOSE BLEEDS	<input type="checkbox"/>	<input type="checkbox"/>
DENTAL PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
DEAFNESS/EAR PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>

ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>
BRONCHITIS	<input type="checkbox"/>	<input type="checkbox"/>
CHEST PAINS	<input type="checkbox"/>	<input type="checkbox"/>
HEART PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>

ULCERS	<input type="checkbox"/>	<input type="checkbox"/>
BOWEL PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
URINARY INFECTIONS	<input type="checkbox"/>	<input type="checkbox"/>
KIDNEY PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
MENSTRUAL PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>
BLOOD TRANSFUSIONS	<input type="checkbox"/>	<input type="checkbox"/>
HEPATITIS	<input type="checkbox"/>	<input type="checkbox"/>
THYROID DISORDER	<input type="checkbox"/>	<input type="checkbox"/>

ALLERGIES    
(SPECIFY) \_\_\_\_\_

FRACTURES    
(SPECIFY) \_\_\_\_\_

OPERATIONS    
(SPECIFY) \_\_\_\_\_

### RECENT WITHIN ONE YEAR:

	YES	NO
INFECTIOUS DISEASE	<input type="checkbox"/>	<input type="checkbox"/>
HEAD INJURY	<input type="checkbox"/>	<input type="checkbox"/>
MAJOR SURGERY	<input type="checkbox"/>	<input type="checkbox"/>
TRAUMATIC OR OVERUSE INJURY	<input type="checkbox"/>	<input type="checkbox"/>

LIST ANY OTHER HEALTH PROBLEMS/RELEVANT INFORMATION OR EXPLAIN ANY OF THE CONDITIONS MARKED 'YES':

### MEDICATIONS CURRENTLY BEING USED

PRESCRIBED: \_\_\_\_\_

NON-PRESCRIBED: \_\_\_\_\_

DATE COMPLETED: \_\_\_\_\_ DATE(S) UPDATED: \_\_\_\_\_

SIGNATURE OF PARENT/GUARDIAN (IF ATHLETE UNDER 18 YEARS)