

# PRE SEASON MEDICAL QUESTIONNAIRE



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 Varsity Sport (circle): 1st 2nd 3rd 4th 5th 6th

Year of Eligibility (circle): None ('Red Shirt') 1st 2nd 3rd 4th 5th

What position will you be playing this year? \_\_\_\_\_

## Health Status Questionnaire:

(explain yes answers below)

- |  |     |    |
|--|-----|----|
| 1. Have you ever been hospitalized? .....  | Yes | No |
| Have you ever had surgery? .....   | Yes | No |
| 2. Are you presently taking any medications or pills? .....  | Yes | No |
| Are you presently taking any vitamins or supplements? .....  | Yes | No |
| 3. Do you have any allergies (medicine, food, bees or other)? .....                                  | Yes | No |
| 4. Have you ever passed out during or after exercise? .....  | Yes | No |
| Have you ever been dizzy during or after exercise? .....   | Yes | No |
| Have you ever had chest pain during or after exercise? .....   | Yes | No |
| Do you tire more quickly than your friends during exercise? .....                                    | Yes | No |
| Have you ever had high blood pressure? .....   | Yes | No |
| Have you ever been told that you have a heart murmur? .....  | Yes | No |
| Do you or have you ever been told you have an irregular heartbeat? .....                             | Yes | No |
| Has anyone in your family died of heart problems or a sudden death before age 50? .....              | Yes | No |
| 5. Do you have any skin problems (itching, rashes, acne)? .....                                      | Yes | No |
| 6. Have you ever had heat or muscle cramps? .....  | Yes | No |
| Have you ever been dizzy or passed out in the heat? .....  | Yes | No |
| 7. Do you have trouble breathing or do you cough during or after activity? .....                     | Yes | No |
| 8. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)? ..... | Yes | No |
| Do you use any dental appliances? .....  | Yes | No |
| 9. Have you had any problems with your eyes or vision? .....   | Yes | No |
| Do you wear glasses or contacts or protective eye wear? .....  | Yes | No |
| 10. Have you had any other medical problems (infectious mononucleosis, diabetes, etc.)? .....        | Yes | No |
| 11. Have you had a medical problem or injury since your last evaluation? .....                       | Yes | No |
| 12. Have you had any unexplained weight change? .....  | Yes | No |
| Do you feel you need to decrease, increase or maintain your current weight? .....                    | Yes | No |
| 13. When was your last tetanus shot? _____   |     |    |
| When was your last measles immunization? _____   |     |    |

Explain "Yes" answers:

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**HEAD INJURIES / CONCUSSIONS:**

15. Have you ever had a seizure?..... Yes      No  
16. Have you ever had a head injury?..... Yes      No  
17. Have you ever had a concussion or been "knocked out", had your "bell rung", or been "dinged"?..... Yes      No

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

<u>Date(s)</u>	<u>Activity at the time</u>	<u>Length of unconsciousness (minutes)</u>	<u>Length of time before full return to activity</u>
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Did you have any persistent problems with:

Memory: YES NO

Dizziness: YES NO

Headaches: YES NO

18. Do you have any incompletely healed injury? ..... Yes      No

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

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

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