



# HEALTH QUESTIONNAIRE

## PERSONAL DATA

Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_ Health Care # \_\_\_\_\_

\_\_\_\_\_

Gender: F  M  Date of Birth(Y/M/D) \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

## EMERGENCY CONTACT

Name \_\_\_\_\_ Phone # (h) \_\_\_\_\_

Address \_\_\_\_\_ Phone # (w) \_\_\_\_\_

Relation \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Family Dentist \_\_\_\_\_ Phone # \_\_\_\_\_

## MEDICAL CONDITIONS

Indicate "yes" or "no" to the following questions and explain any "yes" answers.

YES NO

- Have you ever been hospitalized?  YES  NO
- Do you have any allergies (medicine, bees or stinging insects)?  YES  NO
- Do you or any of your family members have high blood pressure?  YES  NO
- Have you been told that you have a heart murmur?  YES  NO
- Do you or any family members have a history of heart problems?  YES  NO
- Do you have any skin problems (i.e. itching, rashes, acne)?  YES  NO
- Have you passed out or been dizzy during or after exercise?  YES  NO
- Do you have medical conditions that affect participation (diabetes, epilepsy, asthma)?  YES  NO
- Have you had a head injury (i.e. concussion)?  YES  NO
- Have you ever passed out during or after exercise?  YES  NO
- Have you ever had a stinger, burner or pinched nerve?  YES  NO
- Have you ever had heat cramps or muscle cramps?  YES  NO
- Have you had a medical problem since your last season or physical evaluation?  YES  NO

Explain any "yes" answers you have given

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## ORTHOPAEDIC CONDITIONS

If you have injured any bones, joints or muscles that required medical attention, please elaborate.

Body Area	Specific Injury	Right or Left Side	Treatment & Date (Mo./Yr.)
Head\Neck			
Shoulder\Arm			
Wrist\Hand\Fingers			
Chest			
Back			
Pelvis\Hip			
Thigh			
Knee			
Shin\Calf			
Foot\Toes			

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| Do you wear any special equipment (i.e. braces, splints, eye guards)?                           | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you wear glasses, contacts or protective eyewear?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you presently taking any medications or pills?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you missed five games in a row due to injury?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you been treated for any medical conditions in the past three months?                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you wear a dental appliance?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you wear a medic alert bracelet?   | <input type="checkbox"/> | <input type="checkbox"/> |
| List the medications that you are taking for the above mentioned medical conditions or injuries |                          |                          |

How long have you been participating in this sport? \_\_\_\_\_

What other sports do you participate in? \_\_\_\_\_

## CONSENT

I, \_\_\_\_\_, (athlete's name) have completed the medical questionnaire to the best of my knowledge and have not willingly withheld information on any condition or injury for which I had in the past or am currently being treated. I recognize the importance of the medical questionnaire in assisting the Trainers in providing prompt and accurate medical attention. I am aware that the trainers attending to my team may need to clarify any previous condition or injury that I have sustained. I understand that the Trainer will keep this information confidential unless it is necessary to divulge it to another medical practitioner/medical facility.

Athletes Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent's Signature (required if athlete is under legal age) \_\_\_\_\_