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?	☐	☐
Do you have any allergies (medicine, bees or stinging insects)?	☐	☐
Do you or any of your family members have high blood pressure?	☐	☐
Have you been told that you have a heart murmur?	☐	☐
Do you or any family members have a history of heart problems?	☐	☐
Do you have any skin problems (i.e. itching, rashes, acne)?	☐	☐
Have you passed out or been dizzy during or after exercise?	☐	☐
Do you have medical conditions that affect participation (diabetes, epilepsy, asthma)?	☐	☐
Have you had a head injury (i.e. concussion)?	☐	☐
Have you ever passed out during or after exercise?	☐	☐
Have you ever had a stinger, burner or pinched nerve?	☐	☐
Have you ever had heat cramps or muscle cramps?	☐	☐
Have you had a medical problem since your last season or physical evaluation?	☐	☐

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)?	☐	☐
Do you wear glasses, contacts or protective eyewear?	☐	☐
Are you presently taking any medications or pills?	☐	☐
Have you missed five games in a row due to injury?	☐	☐
Have you been treated for any medical conditions in the past three months?	☐	☐
Do you wear a dental appliance?	☐	☐
Do you wear a medic alert bracelet?	☐	☐

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) _____