



PLAYER MEDICAL HISTORY

QUESTIONS OR CONCERNS MAY BE DIRECTED TO THE
ATHLETIC THERAPY TEAM

NAME: _____ **SEX:** _____ **AGE:** _____
BIRTHDAY: _____ **OHIP # (health card #)** _____
ADDRESS: _____ **CITY** _____ **POSTAL CODE** _____
PHONE #: _____ **E-MAIL:** _____
MOTHER: _____ **PHONE #:** _____
FATHER: _____ **PHONE #:** _____
EMERGENCY CONTACT: _____ **PHONE #:** _____
FAMILY PHYSICIAN: _____ **PHONE #:** _____

MEDICAL HISTORY QUESTIONNAIRE

FAMILY HISTORY: Has any member of your immediate family (i.e. parents, grandparents, siblings) had any of the following?

	Y	N		Y	N		Y	N
Sudden death before age 50			Sudden death during sports participation			Obesity or Diabetes		
Allergies			Arthritis			Neurological Disorders		
Cancer			Heart Disease			High Blood Pressure		

MEDICAL HISTORY: Have you ever had any of the following? If **YES**, please provide an explanation in the space provided. When more than one choice is available please circle those that apply to you.

	Y	N		Y	N		Y	N
Appendicitis			Epilepsy/Nervous Disorders			Recurrent Headaches/Migraines		
Asthma/use inhalants			Ear Problems(Infections/swimmers ear/pain/drainage problems)			Vision Problems/Eye Injury Wear Corrective Glasses/Contacts		
Cancer/Anemia/Leukemia			Frequent/Recurrent Nose Bleeds			Surgery/Hospitalizations (non-sports related)		
Diabetes			Hearing Problems/Loss of Hearing/Hearing Aid			Mononucleosis		
Chest Pain/ Chronic Cough/ Coughing Blood			Heart Disease/Heart Murmur/irregular Heart Beat			Been advised NOT to participate in contact sports?		
Circulatory Problems/Bleeding Disorders			Heat Disorders/Heat Stroke/Heat Exhaustion			Do you wear corrective glasses/contacts for sport?		
Dental Injury/ Missing or False Teeth/Dental Appliances			High/Low Blood Pressure High/Low Cholesterol			Do you wear a mouth guard for sport?		
Kidney/Bladder Disease/ Problems								

Explanations: _____

ALLERGIES: List any allergies you have (i.e. drugs/adhesive/insects/plants/food, etc) and describe your reaction and treatment for your allergies.

MEDICATIONS: List any & all prescription &/or nonprescription medications, vitamins/supplements you are currently taking.

IMMUNIZATIONS: List type and date of last immunizations (i.e. Tetanus/Diphtheria/Hepatitis etc).

ADDITIONAL INFORMATION: Include other medical concerns and explanations.

HEAD INJURY AND CONCUSSION HISTORY: Please complete the chart below where applicable:

Date/Year	Mechanism of Injury (Sport)	Unconscious & For How Long	Seen by Doctor?	Hospitalized	How Long Off Sport?	Loss of Memory?	Headaches During/After Severity	Other Symptoms/ Problems

MUSCULOSKELETAL INJURY HISTORY: Please fill out the chart below where applicable and give as much information about the injury as you can.

Past injury to:	Right or left?	Diagnosis (if known)	Date /Year	Seen by Doctor?	Treatment (including surgery, therapy etc)	Still a Problem?
Facial/Skull						
Neck						
Back (bones/disc)						
Ribs/Chest						
Abdomen						
Shoulder						
Upper Arm						
Elbow/Forearm						
Wrist						
Hand/Fingers						
Hip						
Groin						
Thigh						
Knee						
Lower Leg						
Ankle/Foot						
Do you have a pin, screw or plate as a result of surgery? Yes/No Explain						
Have you been advised to have surgery but which has not yet been completed? Yes/No Explain						

ADDITIONAL INFORMATION: _____

I, _____ (Parent/Guardian) give permission to release the medical information of my son _____ (athlete) to the team's Athletic Therapy staff for the sole purpose of safe and proper care and treatment of my son in the understanding that this information will remain confidential and will only be shared with medical personnel in the event of a medical emergency.

SIGNATURE OF ATHLETE: _____ **DATE:** _____

SIGNATURE OF PARENT/GUARDIAN: _____ **DATE:** _____