

## HEALTH QUESTIONNAIRE

### 1 PERSONAL DATA

Name: \_\_\_\_\_ Phone #: 403- \_\_\_\_\_ AHCP# \_\_\_\_\_  
 Address: \_\_\_\_\_ Prov. AB \_\_\_\_\_  
 Gender: M F Date of Birth: \_\_\_\_\_  
 (d/m/y)

### 2 EMERGENCY CONTACT:

Name: \_\_\_\_\_ Phone # (h) \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone # (w) \_\_\_\_\_ Relation: \_\_\_\_\_  
 Family Physician: \_\_\_\_\_ Phone # \_\_\_\_\_  
 Family Dentist: \_\_\_\_\_ Phone # \_\_\_\_\_

### 3 MEDICAL CONDITIONS

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

Have you ever been hospitalized?	YES	NO
Do you have any allergies (medicine, bees, or other 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 (itching, rashes, and 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 medical problems since your last physical?	YES	NO
Explain any "yes" answers you have given _____		

### 4 ORTHOPEDIC CONDITIONS

If you have injured any bones, joints, or muscles that require medical attention, please elaborate:

<u>Body Area</u>	<u>Specific Injury</u>	<u>RT</u>	<u>LT</u>	<u>Date</u>
Head/Neck	_____			
Shoulder/Arm	_____			
Wrist/Hand/Fingers	_____			
Chest	_____			
Back	_____			
Pelvis/Hip	_____			
Thigh	_____			
Knee	_____			
Shin/Calf	_____			
Foot/Toes	_____			

Do you wear any special equipment (braces/splints/eye guards/etc)

Do you wear glasses, contacts, or protective eyewear? YES NO

Are you presently taking any medications or pills? YES NO

Have you missed five (5) games in a row due to injury? YES NO

Have you been treated for any medical conditions in the past 3 months? YES NO

Do you wear a dental appliance? YES NO

Do you wear a medic alert bracelet? YES NO

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? \_\_\_\_\_

### 5 CONSENT

I, \_\_\_\_\_ parents/guardian of \_\_\_\_\_

have completed the medical questionnaire to the best of my knowledge and have not willingly withheld information on any condition or injury for which my child has had in the past or is currently being treated. I recognize the importance of the medical questionnaire in assisting the coaches in providing prompt and accurate medical attention. I am aware that the team staff member attending to my child's injury may need to clarify any previous condition or injury that my child has sustained. I understand that this information will be kept confidential unless it is necessary to divulge it to another medical practitioner/medical facility.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date