SportMedBC

ATHLETE MEDICAL HISTORY FORM

Contact Information

Surname:_____ **Given:**_____

Age: _____ **Height:**_____ **Gender:** _____ **Weight:** _____

Address: _____ **Apartment Number:** _____

Postal Code: _____ **City:** _____ **Province:** _____

Phone Number:_____ **Email:**_____

Emergency Contacts

Name:_____ **Phone Number:**_____

Relationship: _____

Family Doctor: _____ **Phone Number:**_____

Medical Number:_____

Please Complete ***All Questions***:

1. Do you have any allergies? Y / N *List: (i.e. medication, pollen, food)* _____
2. Do you wear glasses / contacts? Y / N *If so, what?* _____
3. Do you experience recurring headaches, double vision, dizziness, blackouts?
   Y / N *If so, what?* _____
   How often? _____
4. Are you diabetic? Y / N *Medication?* _____
5. Do you have epilepsy? Y / N *Medication?* _____
6. Have you had any surgery in the last 3 years?
   Y / N *If so, What?* _____
   When? _____
7. Have you had any broken bones in the last 3 years?
   Y / N *If so, What?* _____
   When? _____
8. Do you have or have you had any heart problems?
   Y / N *If so What?* _____
   When? _____
   Medication? _____

9. Have you ever had ankle problems?

Y / N *If so, What?* ____________________

When? ____________________

10. Have you ever had knee problems?

Y / N *If so, What?* ____________________

When? ____________________

11. Have you ever had groin/hip problems?

Y / N *If so, What?* ____________________

When? ____________________

12. Have you ever had shoulder / arm / elbow problems?

Y / N *If so, What?* ____________________

When? ____________________

13. Do you experience back or neck pain?

Y / N *(circle one) hardly ever / often / all the time*

What causes it? ____________________

14. Do you experience asthma?

Y / N *Medication?* ____________________

15. Have you seen a doctor for any / all of the conditions listed in questions 8-14?

Y / N *If so, which conditions?* ____________________

____

____

16. Is there anything not listed that the medical staff should be made aware of?

Y / N *If so, PLEASE list:(ie. current medication, concussions)*

____________________ ____________________

____________________ ____________________

Please note that any information given will remain confidential unless deemed appropriate / relevant to divulge to appropriate personnel.

(I.e. in case of emergency / serious injury where participation is halted).

- -

I, (name of athlete/ guardian) ______________________________ *declare that all information given is true and accurate.*

Athlete's Signature ____

Date (mm/dd/yyyy) ____