MEDICAL HISTORY FORM

ATHLETE'S SURNAME:_____ ATHLETE'S GIVEN NAME:_____

ADDRESS:_____ DATE OF BIRTH (M/D/Y): _____

_____ GENDER: _____ LANGUAGES SPOKEN: _____

_____ PROVINCIAL MEDICAL NO: _____

NAME OF PLAN / COMPANY:_____ MEDICAL INSURANCE NO: _____

EMERGENCY CONTACTS

NAME: _____ PHONE: _____

NAME: _____ PHONE: _____

FAMILY PHYSICIAN: _____ PHONE: _____

MEDICAL HISTORY

CURRENT ILLNESSES OR DIAGNOSED SYMPTOMS (RECENT WITHIN ONE YEAR)

	N	Y	(SPECIFY)		N	Y	(SPECIFY)
HEAD INJURY				ASTHMA			
NECK INJURY				BRONCHITIS			
BACK PROBLEMS				CHEST PAINS			
EYE PROBLEMS				HEART PROBLEMS			
GLASSES/CONTACTS				MENSTRUAL PROBLEM			
NOSE BLEEDS				BOWEL PROBLEMS			
DENTAL PROBLEMS				URINARY INFECTIONS			
DEAFNESS				KIDNEY PROBLEMS			
EAR PROBLEMS				EATING DISORDERS			
SEIZURES				DIABETES			
FAINTING SPELLS				THYROID DISORDER			
BLOOD TRANSFUSIONS				HEPATITIS			
TRAUMATIC INJURY				INFECTIOUS DISEASE			
FRACTURES				MENTAL DISORDER			
OVERUSE INJURY				OPERATIONS			
SPRAINS				MAJOR SURGERY			

ALLERGIES	N	Y	(SPECIFY)		N	Y	(EXPIRY DATE)
FOOD				EpiPen			
OTHER				EpiPen			

***LIST ANY OTHER RELEVANT HEALTH CONDITIONS OR PROVIDE ANY FURTHER EXPLAIN ANY OF THE CONDITIONS MARKED "YES":**

_____

_____

_____

MEDICATIONS CURRENTLY USED

PRESCRIBED: _____ DATE COMPLETED: _____

NON PRESCRIBED: _____ SIGNATURE OF PARENT/GUARDIAN _____