MEDICAL HISTORY FORM

ATHLETE'S SURNAME:____________________________

ATHLETE'S GIVEN NAME:____________________________

ADDRESS:____________________________

____

____

DATE OF BIRTH (M/D/Y): ____________________________

HEIGHT: ______________WEIGHT: ______________

BLOOD GROUP & TYPE: ____________________________

PROVINCIAL MEDICAL NO: ____________________________

MEDICAL INSURANCE NO: ____________________________

FAMILY PHYSICIAN: ____________________________

PHONE: ____________________________

NEXT OF KIN: ____________________________

PHONE: ____________________________

IN CASE OF EMERGENCY
PLEASE NOTIFY: ____________________________

PHONE: ____________________________

OUTLINE PAST HISTORY OR ILLNESS

HAVE YOU EVER HAD OR DO YOU NOW HAVE:

	YES	NO
HEAD INJURY	___	___
SEIZURES	___	___
NECK/BACK DISRODER	___	___
FAINTING SPELLS	___	___
PSYCHIATRIC DISORDER	___	___
EYE PROBLEMS	___	___
GLASSES/CONTACTS	___	___
NOSE BLEEDS	___	___
DENTAL PROBLEMS	___	___
DEAFNESS/EARPROBLEMS	___	___
ASTHMA	___	___
BRONCHITIS	___	___
CHEST PAINS	___	___
HEART PROBLEMS	___	___
ULCERS	___	___
BOWEL PROBLEMS	___	___
URINARY INFECTIONS	___	___
KIDNEY PROBLEMS	___	___
MENSTRUAL PROBLEMS	___	___
EATING DISORDERS	___	___

	YES	NO
DIABETES	___	___
BLOOD TRANSFUSIONS	___	___
HEPATITS	___	___
THYROID DISORDER	___	___
ALLERGIES (SPECIFY)	___	___
FRACTURES (SPECIFY)	___	___
OPERATIONS (SPECIFY)	___	___
RECENT WITHIN ONE YEAR:		
INFECTIOUS DISEASE	___	___
HEAD INJURY	___	___
MAJOR SURGERY	___	___
TRAUMATIC OR OVERUSE INJURY	___	___

***PLEASE LIST ANY OTHER HEALTH PROBLEMS OR RELEVANT INFORMATION OR EXPLAIN ANY OF THE CONDITIONS MAKED "YES":**

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____

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MEDICATIONS CURRENTLY USED

PRESCRIBED: ____________________

NON PRESCRIBED: ________________

DATE COMPLETED: ____________________________

SIGNATURE OF PARENT/GUARDIAN ____________________________