



# 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 DISORDER	___	___
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	___	___
HEPATITIS	___	___
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 MADE "YES":**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICATIONS CURRENTLY USED**

PRESCRIBED: \_\_\_\_\_

DATE COMPLETED: \_\_\_\_\_

NON PRESCRIBED: \_\_\_\_\_

SIGNATURE OF PARENT/GUARDIAN \_\_\_\_\_