**Football Medical Form 2018**

Last Name:      First Name:

Address:      City/Town:      Province:      Postal Code:

Home Phone Number:

Date of Birth (dd/mm/yyyy):      Alberta Heath Care Number:

Emergency Contact (Name):      Relationship (i.e. Father, Aunt):

Emergency Contact Phone Number:

Family Doctor’s Name:      Family Doctor’s Phone Number:

**HAVE YOU EVER HAD OR DO YOU NOW HAVE**

|  |  |  |  |
| --- | --- | --- | --- |
| Heat Stroke/Cramps  Infectious Mononucleosis  Scarlett or Rheumatic Fever  Tonsillitis/Sinusitis  Coughed up blood  Asthma  Severe tooth or gum troubles  Stomach Ulcers  Pneumonia or Tuberculosis  Anemia or low iron  Hepatitis or liver trouble  Hernia or rupture  Piles or hemorrhoids  Tumor or cancer  Used alcohol  Frequent or painful urination  Sexually transmitted disease  Skin rashes |  | Arthritis  Irregular Heart Beats  High or low blood pressure  A heart murmur  Ear or Hearing Trouble  Difficulties with vision  Frequent or Severe Headaches  Epilepsy  Dizziness or fainting spells  “Stingers” or “burners”  Concussion or been “knocked out”  Loss of Memory  Any mental illness  Motion sickness  Smoked cigarettes  Kidney stones or blood urine  Used non-prescription/street drugs  Diabetes |  |

**ANY ALLERGIES?**

Allergies to medication?      What is the reaction?

Allergies to food?      What is the reaction?

Allergies to animals and insects?      What is the reaction?

Any other allergies?      What is the reaction?

DO YOU HAVE AN EPI PEN**®?**

**ANY DISEASE?**

Have you had a disease in the last 12 months? If YES, which disease?

Have you ever had to stay in hospital overnight? If YES, what for?

Have you ever had any surgery? If YES, what for?

Have you ever had any broken bones? If YES, which bones?

Do you wear contact lenses or glasses? If YES, which do you play sports with?

Do you have an eye condition that requires a tinted visor while playing football? If YES, please attach note from doctor.

Have you seen a physiotherapist and/or chiropractor? If YES, what for?

Do you have any pins, plates or screws in your body from any bone or joint surgery? If YES, where?

Do you wear any dental appliances such as braces or a plate?

**FAMILY HISTORY:** Please indicate any illnesses that have affected family members past or present.

Diabetes, Allergies, Arthritis, Neurological Disorders, Gout, Heart Disease, High Blood Pressure, High Cholesterol, Bleeding Problems, Kidney Disease, Mental Illness, Sickle Cell Anemia

Specify:

Has anyone in your family died suddenly before the age of 40?

**ARE YOU TAKING ANY MEDICATIONS?**

If YES, please list

**ARE YOU TAKING ANY SUPPLIMENTS?**

If YES, please list

**WHEN WERE YOUR IMMUNIZATIONS LAST UPDATED (Including Tetanus)**

(dd/mm/yyyy)

**CHECK ANY OF THE AREAS THAT YOU HAVE INJURED IN THE PAST AND EXPLAIN THE INJURY BELOW:**

Hand Elbow Neck Hip Shin/calf Wrist Knee Foot Arm Chest Thigh Ankle Forearm Shoulder Back Neck

**ANY DIETERY RESTRICTIONS?**

Allergies to food?

Vegetarian diet?

Gluten-free diet?

Any other dietary restrictions?