**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 MononucleosisScarlett 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 BeatsHigh or low blood pressureA heart murmurEar or Hearing TroubleDifficulties with visionFrequent or Severe HeadachesEpilepsyDizziness or fainting spells“Stingers” or “burners” Concussion or been “knocked out”Loss of MemoryAny mental illnessMotion sicknessSmoked cigarettesKidney stones or blood urineUsed non-prescription/street drugsDiabetes | [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  |

 **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?