
# Athlete Medical Questionnaire

Name:_____ Date of Birth (m/d/y): _____ Age: ____

Address: _____

Emergency Contact Name: _____ Contact number: _____

Relation : _____

Health card # (OHIP): _____

Extended Healthcare (Y/N): _____

* For the following questions please just circle Yes or No. If questions are answered with a YES please elaborate

General

1. Do you suffer or have suffered from the following conditions in the past: Cardiovascular disease, Respiratory disorder, blood disorder (clotting issues), diabetes , epilepsy, fainting spells? (Y/N)

2. Do you have a family history of heart disease, high blood pressure, diabetes, or unexplained death under the age of 50? (Y/N)

3. Have you ever had surgery? If so list what surgery.

4. Has a doctor ever denied or restricted your participation in sports for any reason? (Y/N) If so why?

6. Are you allergic to anything? If so please list all the items you are allergic to. (Y/N)

7. Are you on any mediation? If so please list them all. (Y/N)

8. Have you ever passed out or nearly passed out DURING of AFTER exercise? (Y/N)

9. Have you ever experienced discomfort, pain or pressure in your chest as a result of exercise? (Y/N)

10. Have you ever suffered a heat injury, such as heat exhaustion or heat stroke? (Y/N)

11. Do you get ill when you exercise in heat? (Y/N)

12. Have you experienced any unexplained weight loss recently? (Y/N)

13. Have you ever suffered from mono? (Y/N)

14. Do you have a history of any of the following: (Please circle all those that apply)

birth defects chicken box hepatitis HIV hernia Kidney disease

Measles mental disorder pneumonia sickle cell trait/disease tuberculosis

## **Head and Neck**

1. Have you ever had a diagnosed concussion? (Y/N)
   if yes, how many and when_____

2. When was your last concussion? _____

3. Have you ever been knocked out, become unconscious or lost your memory? (Y/N)

4. Do you frequently suffer from severe headaches or have been diagnosed with a migraine? (Y/N)

**Heart**

2. Have you ever been told you have the following

a) high blood pressure (Y/N)
b) high cholesterol (Y/N)
c) a heart murmur (Y/N)
d) heart arrhythmia (Y/N)

**Lungs**

1. Have you ever been diagnosed with Asthma? (Y/N)

2. Have you ever gotten unexpectedly short of breath with exercise? (Y/N)

3.Do you cough or wheeze during or after exercise? (Y/N)

4. Do you have seasonal allergies that require medical treatment (i.e. medication)? (Y/N)

**Orthopedic Injuries**

1. Have you ever had a broken bone? (Y/N). IF yes please specify.

2. Do you have a pin, screw, or plate anywhere in your body as a result of bone or joint surgery? (Y/N)

3. Have you ever experienced a sprain of the knee or ankle that resulted in swelling? (Y/N) If yes, please describe:

4. Have you ever been advised to have surgery to correct a knee problem? (Y/N)

5. Have you ever had a hamstring OR thigh muscle injury? (Y/N) IF yes, how many times?

6. Have you ever had a groin/hip flexor muscle injury? (Y/N)

**Other**

If there are other notable injuries or health conditions that were not included above please list them below.