

HEALTH QUESTIONNAIRE

Last Name: _____ First Name: _____

Address: _____ City: _____

Prov: _____ Postal Code: _____ Home #: _____

Email: _____ Cell #: _____

Birthdate: ___/___/___ Male ___ Female ___ AHC# _____
Year/month/day

Emergency Contact Information:

Name: _____ Relationship to Athlete: _____

Phone:(H) _____ (B) _____ (cell) _____

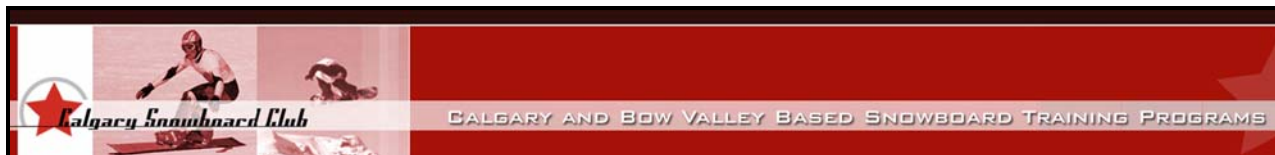
Family Physician: _____ Phone: _____

PLEASE COMPLETE THE FOLLOWING WITH AS MUCH ACCURACY AS POSSIBLE BY CIRCLING THE APPROPRIATE RESPONSE:

Family History:

- | | | |
|---|---|---------------------------------------------------------|
| Y | N | Has anyone in your family (under age 50) died suddenly? |
| Y | N | High blood pressure |
| Y | N | Cancer or tumour |
| Y | N | Migraine or headaches |
| Y | N | Emotional problems |
| Y | N | Anemia |
| Y | N | Diabetes |
| Y | N | Epilepsy |
| Y | N | Kidney/bladder disorder |
| Y | N | Stomach disorder |

Specify: _____



Do you at the present time experience any of the following:

- Y N Difficulties with your eyes or vision?
- Y N Difficulties with your nose or throat?
- Y N Problems with hearing?
- Y N Headaches, dizziness, weakness, fainting, any problems with co-ordination or balance?
- Y N Numbness in any part of the body?
- Y N Any tendency to shake or tremble?
- Y N Cough, shortness of breath, chest pain or palpitations?
- Y N Poor appetite, vomiting, abdominal pain, abnormal bowel habits?
- Y N Stiffness, swelling, pain symptoms in muscles, bones or joints?
- Y N Skin problems such as sores, rashes, itchy or burning sensations, Etc.?
- Y N Other symptoms?

Have you ever had, or been told you had, or consulted a physician for:

- Y N Diabetes, goiter or other diseases of the glands?
- Y N Have you been diagnosed with Mono within the last year? If so please provide details.
- Y N Epilepsy?
- Y N Nervous disorder or any disease of the brain or nervous system?
- Y N Heart trouble or rheumatic fever?
- Y N Varicose veins, phlebitis, hemorrhoids or hernias?
- Y N Any tendency of the blood toward easy bruising or bleeding?
- Y N Tuberculosis, asthma or any lung disease or respiratory disorder?
- Y N Ulcers or any disease of the stomach, intestines, liver or gallbladder?
- Y N Sugar, albumin or blood in the urine or any disease of the kidney?
- Y N Arthritis, rheumatism or any injury or disease of the bones, peripheral joints, back Or spine?
- Y N Cancer, tumour or growth of any kind?
- Y N Have you ever had a head injury causing severe dizziness, loss of memory, vomiting, unconsciousness or requiring medical attention or hospitalization? If yes, please specify:

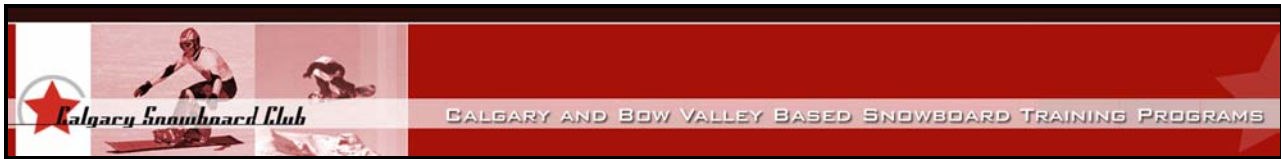
Cold Disorder:

- Y N Have you ever suffered from hypothermia?
- Y N Have you ever suffered from frostbite?

Drug, Food, Supplements and Miscellaneous Agents:

Are you presently taking any of the following, if so please specify

- Y N Medications/Prescription Drugs
- Y N Vitamins
- Y N Stimulants
- Y N Anabolic agents
- Y N Sleeping pills



Drug, Food, Supplements and Miscellaneous Agents Con't:

- Y N Non-prescription drugs not listed above
- Y N Do you smoke? If yes, how many a day?
- Y N Do you drink alcoholic beverages? If yes, how much do you consume in a day?
- Y N Have you ever been advised for medical reasons not to participate in sport for any period?
- Y N Do you wear glasses for sports?
- Y N Do you wear contacts lenses for sports? If yes, are they soft____ or hard____?

Previous Injuries and/or Surgeries

Type: _____ Date: _____
Type: _____ Date: _____
Type: _____ Date: _____
Type: _____ Date: _____

ALL INFORMATION GATHERED IS PROTECTED UNDER THE FOIPP AND WILL BE KEPT CONFIDENTIAL. IT WILL BE USED ONLY IN THE EVENT OF A MEDICAL EMERGENCY.

ATHLETE AUTHORIZATION

The health history provided in this form is correct, to the best of my knowledge. The person herein described has permission to engage in all prescribed coaching activities, including out trips, except as noted by the above physician and myself. In the event that I cannot be reached in and EMERGENCY, I hereby give my permission to the Coach, Team Manager and/or Trip Coordinator as well as Emergency Physicians to hospitalize my child as named.

Please Print Name: _____ Date: _____

Signature: _____

PARENT/GUARDIAN AUTHORIZATION (if athlete is under 18 years of age)

Athletes Name: _____

Please Print Name: _____ Date: _____

Signature: _____