

TORONTO WILDCATS 2004 MEDICAL INFORMATION

Family Name: _____ Given Name: _____
Health Card #: _____ Version Code: _____ Province: _____
Football Position: _____ Date of Birth: (D/M/Y) _____
Address: _____ City: _____ Province: _____
Postal Code: _____ Phone #: () _____

In case of emergency please notify:

Name or names: _____
Relationship to you: _____
Home Phone #: () _____ Work Phone #: () _____
Name of Family Physician: _____ Phone #: () _____

MEDICAL HISTORY

Answer each question by circling the appropriate **Yes** or **No**.
Have you ever had or have you now: (circle each item)

DETAILS

- | | | |
|---|-----|----|
| 1. Epilepsy or Epileptic Seizures | Yes | No |
| 2. Hepatitis/Jaundice | Yes | No |
| 3. Infectious Mononucleosis, Viral
Pneumonia, Herpes, or any other
Infectious disease in the past 12 months | Yes | No |
| 4. Diabetes | Yes | No |
| 5. Scarlet Fever/Rheumatic Fever | Yes | No |
| 6. Recurrent Nose Bleed | Yes | No |
| 7. Heart Murmur | Yes | No |
| 8. Allergies (i.e. bee sting; drugs; food) | Yes | No |
| 9. Concussion/Knocked out/Bell rung | Yes | No |
| 10. Skin Disorders | Yes | No |
| 11. Hernia | Yes | No |
| 12. Surgery/Operation | Yes | No |
| 13. Thyroid Problem | Yes | No |
| 14. Dizziness | Yes | No |
| 15. Hearing Problems | Yes | No |
| 16. Visual Problems/Injuries | Yes | No |
| 17. Motion Sickness | Yes | No |
| 18. Mental Illness | Yes | No |
| 19. High Blood Pressure | Yes | No |
| 20. Hypertension | Yes | No |
| 21. Fainting Spells | Yes | No |
| 22. Chest Pains | Yes | No |
| 23. Palpitations | Yes | No |
| 24. Irregular Heart Beat | Yes | No |
| 25. Asthma | Yes | No |
| 26. Difficulty Breathing | Yes | No |
| 27. Digestive Problems | Yes | No |
| 28. Kidney Stone | Yes | No |
| 29. Blood in Urine | Yes | No |
| 30. Other Kidney Problems | Yes | No |
| 31. Tumor/Growth/Cyst | Yes | No |

32. Broken Bones/Fractures	Yes	No
33. Dislocation/Separation/Subluxation	Yes	No
34. Torn Ligaments/Cartilage	Yes	No
35. Tendon/Muscle Injury	Yes	No
36. Arthritis	Yes	No
37. Back Pain/Problems	Yes	No
38. Other Chronic Problems	Yes	No
39. Heat Cramps/Exhaustion/Stroke	Yes	No
40. Exercise Induced Fainting	Yes	No
41. Missing Organs	Yes	No
42. Sickle Cell Anemia	Yes	No

Comments: _____

EYES

Answer questions by circling the appropriate **Yes** or **No**.

- | | | |
|--|-----|----|
| 1. Do you wear eyeglasses? | Yes | No |
| 2. Do you wear contact lenses? | Yes | No |
| 3. If answer is Yes , do you wear them during athletic participation? | Yes | No |

DENTAL

Answer questions by circling the appropriate **Yes** or **No** or correct answer.

- | | | |
|---|-----|----|
| 1. Do you have a family dentist? | Yes | No |
| If Yes , name of family dentist and phone no.: _____ | | |
| 2. When was your last dental checkup/cleaning? Please circle appropriate answer:
<i>Less than 6 months/6 months to 1 year/more than 1 year</i> | | |
| 3. Do you wear any removable dental appliances while competing? | Yes | No |
| 4. Do you currently wear braces (orthodontics)? | Yes | No |
| 5. Have you damaged or lost any teeth due to injury? | Yes | No |
| 6. Do you have any caps/crowns/veneers on your front teeth? | Yes | No |
| 7. Have you ever fractured/dislocated your jaw? | Yes | No |
| 8. Do you use chewing tobacco? | Yes | No |

FAMILY HISTORY

Has any of your family ever had (If yes, please circle):

Arthritis, Neurological Disorder, Gout, Heart Disease, High Blood Pressure, Bleeding Problems, Kidney Diseases, Mental Illness, Sickle Cell Anemia, Sudden Death.

IMMUNIZATIONS

Answer questions by circling the appropriate **Yes** or **No**.

- | | | |
|---|------------|-----------|
| 1. Have you ever had a Hep.B immunization? | Yes | No |
| 2. Have you ever been tested for HIV? | Yes | No |
| 3. What was the date of your last tetanus immunization? _____ | | |

List all medications presently taking (including over the counter, vitamins, herbs and prescription): _____

CERTIFICATION

I certify that I have made full and complete disclosure concerning any and all illnesses, allergies, injuries, physical characteristics and conditions and I have answered completely and truthfully any and all questions asked of me by the attending Head Athletic Therapist.

Date

Athlete

Date

Parent/Guardian

Date

Head Athletic Therapist

CONSENT

The athlete hereby irrevocably consents to the release of all information contained in, or arising from, this medical examination and questionnaire to the appropriate members of the staff of the Toronto Wildcats for which the medical examination was done.

Date

Athlete

Date

Parent/Guardian