ATHLETE HEALTH QUESTIONNAIRE

Event: One-on-One Program

- *This questionnaire is to be completed by the athlete (parent or guardian).*
- *Please use capital letters.*

GENERAL INFORMATION :

Surname: _____ **Given names:** _____ **Age :** _____

Provincial medical insurance no : _____ **Province of registration:** _____

Medic alert bracelet (yes/no)_____ **Reason :** _____

Blood type : _____ **Date of birth (d/m/y) :** _____

Allergies : _____

Medications : _____

_____

Home address (city/province/postal code) :

_____

Home telephone : _____
Fax :_____ **E-mail :** _____

Temporary address (if different) and telephone number :

_____

Family physician's name : _____ **Telephone :**_____

Family physician's address : _____

Date of last medical exam : _____

Family dentist's name : _____ **Telephone :**_____

Family dentist's address : _____

Date of last dental exam : _____

FAMILY HISTORY : Please identify any health problems (past or present) that have occurred in your immediate family: (yes / no)

Y	**N**	**Has anyone in your family (under age 50) died suddenly??**	**Y**	**N**	**Allergies/asthma**
Y	**N**	**High blood pressure**	**Y**	**N**	**Anaemia**
Y	**N**	**Heart trouble**	**Y**	**N**	**Diabetes**
Y	**N**	**Cancer or tumour**	**Y**	**N**	**Epilepsy**
Y	**N**	**Migraine headaches**	**Y**	**N**	**Kidney/bladder disorder**
Y	**N**	**Emotional problems**	**Y**	**N**	**Stomach disorder**
		specify :	**Y**	**N**	**Genetic disorder**

ORTHOPAEDIC HISTORY: Please indicate all significant orthopaedic injuries (fracture, contusion, strain, or sprain) to a muscle, joint or vertebrae, beginning with the most recent:

_____ Date : _____

_____ Date : _____

_____ Date : _____

_____ Date : _____

_____ Date : _____

_____ Date : _____

_____ Date : _____

_____ Date : _____

Please specify if surgery was needed (plate, screw, pin) or if permanent incapacities or sequella happened (e.g., orthotics, braces, loss of strength or stability) :

_____
_____
_____
_____
_____
_____
_____
_____

GENERAL HEALTH: Have you ever had, or been told you had, or are you currently experiencing any of the following conditions? For "yes" answers, elaborate under the chart (please include details of surgeries and dates)

Y	**N**	Difficulties with your eyes or vision? Do you wear glasses, contact lenses for sports?
Y	**N**	Problems with hearing? Are you using hearing aids?
Y	**N**	Dental problems? Are you using dental prosthesis?
Y	**N**	Any problems with the skin such as sores, rashes, itchy or burning sensation, athlete's foot, plantar warts, sun sensitivity or sensitivity to different products, psoriasis, contact dermatitis
Y	**N**	Difficulties with your nose or throat?
Y	**N**	Any problems with your respiratory system or lungs? e.g., asthma, allergies to dust, tuberculosis, cough, shortness of breath, pneumonia
Y	**N**	Any problems with your digestive system? e.g, stomach, liver, gall bladder, bowel and bladder, ulcers, vomiting, nausea, food intolerance, abdominal pain**,** infection, hepatitis
Y	**N**	Any problems with your nervous system? e.g., numbness, shaking, loss of strength, poor reflexes, loss of balance, migraines, fainting, epilepsy, concussion or head injury (if so, specifiy number and degree of importance)
Y	**N**	Any disease of the glands? : e.g., diabetes, mononucleosis, goitre, thyroid
Y	**N**	Any problems with your cardio-vascular system? e.g., varicose veins, phlebitis, haemorrhoids, heart trouble, rheumatic fever, high or low blood pressure
Y	**N**	Any inflammatory problems? e.g., joint swelling, arthritis
Y	**N**	Any disease of the blood? e.g., tendency to bruising, bleeding, anaemia
Y	**N**	Any problems with your reproductive system/gynaecology? e.g., pain during periods, abnormal bleeding, irregular cycles, hormonotherapy, infection
Y	**N**	Have you ever had cancer or a tumour?

Details :

_____
_____
_____
_____
_____

Surgeries :

_____
_____
_____
_____
_____

HEATH DISORDER/ WEIGHT / NUTRITIONAL HABITS:

Have you ever had trouble with dehydration? (excess loss of salt and water) ?_____

Have you ever had heat stroke? _____

If yes, were you hospitalized for heat stroke? _____

Other heat disorder? (specify) _____

Current weight: (Kg/lbs)?: _____ Height (meter/feet) : _____

Do you think you are too heavy for your sport? _____

Has your weight changed in the last year? Gain :_____ loss : _____

Any explanation for this weight change? _____

Are you following a particular diet? _____

If yes, which one?; _____

Anything that you don't eat? _____

What and why? _____

MEDICATION/ SUPPLEMENTS/ OTHER SUBSTANCES : Please specify under the chart for any "yes" answers.

Y	**N**	Do you currently take any medications (over the counter or prescription)?
Y	**N**	Are you taking vitamins or any other supplements?
Y	**N**	Are you taking any stimulants? (benzedrin, amphetamins, etc) :
Y	**N**	Are you taking any anabolic substance or growth hormone?
Y	**N**	Are you taking sleeping pills?
Y	**N**	Do you smoke? If yes, how many cigarettes a day?
Y	**N**	Do you drink alcoholic beverages? If yes, how much per week?

Details:

_____
_____
_____
_____
_____

VACCINATION: Please list all your valid vaccinations. Please note that *tetanus vaccination is strongly recommended* (valid for 10 years).

_____
_____
_____
_____
_____

CONSENT FOR TRANSMITTAL OF INFORMATION:

I, _____, give my permission for the transmittal of the results of this medical examination to the different persons working with the team (physiotherapist, athletic therapist, doctor, coach and manager). However, this document is confidential and the details contained in it cannot be transmitted to another party without my consent (or my parent or guardian).

Signature :_____ Date : _____

RECORD OF CONSENT FOR MEDICAL INTERVENTION:

I, _____ (athlete, parent or guardian) agree that the therapists/doctors working for the _____ travelling to _____ in _____ give the proper emergency care and prevention and all the other treatments relevant to their professions to me _____ (to my son/daughter_____).

It is understood that as soon as possible, I will be informed of the problem, diagnosis, medical treatment required and the expected results.

Signature :_____ Date : _____

In case of emergency, please notify :

Name : _____**Relationship :**_____

Address :_____

Telephone : _____