ATHLETE HEALTH QUESTIONAIRE
(FIRST YEAR)

PERSONAL INFORMATION

		SPORT	POSITION
LAST NAME	FIRST NAME		STUDENT ID #
MALE ☐ FEMALE ☐	DATE OF BIRTH (DAY / MONTH / YEAR)		CITIZENSHIP
PRIMARY PHONE # ( ) CIRCLE ONE CELL PHONE HOME PHONE	ALTERNATE PHONE # ( ) CIRCLE ONE CELL PHONE HOME PHONE		
EMAIL			

CURRENT ADDRESS		PERMANENT ADDRESS	
SUITE / APARTMENT #		SUITE / APARTMENT #	
CITY	PROVINCE / STATE	CITY	PROVINCE / STATE
POSTAL CODE	COUNTRY	POSTAL CODE	COUNTRY

MEDICAL INFORMATION

PROVINCIAL INSURANCE NUMBER		EXPIRY DATE (M / Y)	PROVINCE
PRIMARY DOCTOR	PROVINCE	CITY	PHONE ( )
IN CASE OF EMERGENCY, CONTACT	RELATIONSHIP	PHONE 1 ( )	PHONE 2 ( )
MEDICAL ALERTS			
ALLERGIES			
MEDICATIONS			
PRIMARY INSURANCE COMPANY	POLICY NUMBER	PHONE ( )	FAX ( )

CONSENT FOR TRANSMITTAL & CERTIFICATE OF INFORMATION

I, (PRINT NAME) _____

SIGNATURE _____ DATE (D / M / Y)

1. HEREBY DECLARE THAT ALL OF THE INFORMATION IN THIS ATHLETE HEALTH QUESTIONAIRRE IS COMPLETE AND TRUE.
2. GIVE MY PERMISSION FOR TRANSMITTAL OF THE RESULTS OF THIS MEDICAL EVALUATION AND SUBSEQUENT MEDICAL INFORMATION TO THE SPORTS MEDICINE UNIT STAFF, ATHLETICS DIRECTOR, ASSOCIATE DIRECTOR, AND COACHING STAFF AT CONCORDIA UNIVERSITY.
3. UNDERSTAND THAT THE DEPARTMENT OF RECREATION AND ATHLETICS AT CONCORDIA UNIVERSITY DOES NOT HAVE INSURANCE FOR STUDENT ATHLETES AND THAT IT IS MANDATORY THAT I ENROLL IN THE STUDENT INSURANCE PLAN OFFERED THROUGH MY STUDENT ASSOCIATION, OR THAT I HAVE OTHER INSURANCE COVERAGE.
4. UNDERSTAND THAT I AM OBLIGATED TO INFORM THE ATHLETIC THERAPY STAFF AT CONCORDIA UNIVERSITY OF ANY CHANGE IN MY MEDICAL STATUS WHILE I AM A VARSITY ATHLETE AT CONCORDIA UNIVERSITY.

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MEDICAL HISTORY

LIST PAST MEDICAL ILLNESSES OR INJURIES OR HOSPITALIZATIONS		
LIST PREVIOUS SPRAINS, STRAINS OR SWELLING OF YOUR JOINTS		
LIST PREVIOUS BROKEN BONES OR DISLOCATED JOINTS		
LIST CURRENT ACHES AND PAINS IN MUSCLES, JOINTS OR BONES		
LIST PAST SURGERIES	DATE	DOCTOR
LIST PAST SURGERIES	DATE	DOCTOR
LIST ANY SUPPLEMENTS TAKEN WITHIN THE PAST 6 MONTHS		

IF YOU ANSWER YES TO ANY OF THE FOLLOWING QUESTIONS PLEASE EXPLAIN THE SPECIFIC ITEM IN DETAIL.

HAVE YOU EVER PASSED OUT DURING OR AFTER EXERCISE?	YES	NO
HAVE YOU EVER BEEN DIZZY, HAD CHEST PAIN, A RACING HEARTBEAT DURING OR AFTER EXERCISE?	YES	NO
HAVE YOU EVER BEEN TOLD YOU HAVE A HEART MURMUR?	YES	NO
HAS ANY FAMILY MEMBER OR RELATIVE DIED OF HEART PROBLEMS OR SUDDEN DEATH BEFORE THE AGE OF 50?	YES	NO
HAVE YOU EVER HAD A HEAD INJURY, BEEN DINGED OR HAD A CONCUSSION? IF YES, HOW MANY AND WHEN WAS YOU LAST ONE?	YES	NO
DO YOU EVER HAVE FREQUENT OR SEVERE HEADACHES?	YES	NO
HAVE YOU EVER BECOME ILL FROM EXERCISING IN THE HEAT?	YES	NO
DO YOU EVER COUGH, WHEEZE, OR HAVE TROUBLE BREATHING DURING OR AFTER ACTIVITY?	YES	NO
HAVE YOU EVER HAD NUMBNESS OR TINGLING IN YOUR ARMS, HANDS, LEGS, OR FEET OR HAD A STINGER, BURNER, OR A PINCHED NERVE??	YES	NO
DO YOU HAVE ANY CURRENT SKIN PROBLEMS (RASHES, BLISTERS, ETC.)?	YES	NO
DO YOU WHERE CONTACT LENSES OR EYEGLASSES?	YES	NO
ARE YOUR PERIODS REGULAR? HOW MANY HAVE YOU HAD IN THE PAST YEAR?	YES	NO
WHAT WAS THE LONGEST TIME BETWEEN PERIODS IN THE LAST YEAR?	YES	NO
ARE YOU CURRENTLY TAKING BIRTH CONTROL PILLS?	YES	NO
WHEN WAS YOUR LAST PAP TEST?	(MONTH/YEAR)	

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PHYSICAL EXAMINATION

TO BE COMPLETED BY A PHYSICIAN. PLEASE PROVIDE DETAILED INFORMATION FOR AREAS OF CONCERN OR AREAS PREVIOUSLY INJURED

HEIGHT (INCHES)	WEIGHT (LBS)	BLOOD PRESSURE	HEART RATE (BPM)	RESPIRATION (PER MINUTE)

RESPIRATORY	ASTHMA, ETC.
CARDIOVASCULAR	MURMURS, EXTRA HEART SOUNDS, ABNORMAL RHYTHMS, ETC.
ABDOM EN	MASSES, ORGANOMEGALY, ETC.
GENITALIA	UNDESCENDED TESTICLES, HERNIAS, TANNER STAGES, TUMORS
EYES	VISUAL ACUITY R/20 L/20
OROPHARYNX	FRACTURED TEETH, MOUTHGUARD ISSUES
EARS	INFECTIONS
NEUROLOGICAL	MYOTOME AND DERMATOME DEFICIENCIES
MUSCULOSKELETAL	ORTHOPEIDIC CONCERNS
OTHER MEDICAL CONCERNS	

I VERIFY THAT _____ IS IN GOOD HEALTH AND PERMITTED TO PARTICPATE IN ALL SPORTS.

IF NOT, PLEASE EXPLAIN:

_____

DATE (D / M / Y)	PHYSICIAN NAME:	SIGNATURE
/ /	LICENCE #	TEL #:

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NOTES