PRE-SEASON
MEDICAL QUESTIONNAIRE

NORTHWEST CALGARY
ATHLETIC ASSOCIATION

Contact Information					
NAME (First & Last Name)					
ADDRESS (City & Postal Code)					
PHONE NUMBER					
EMAIL					
DATE OF BIRTH (Day, Month, Year)				AGE	
MEDICAL NUMBER				PROVINCE	
PRIVATE INSURANCE	Yes	No			
	Company				
FAMILY PHYSICIAN	Name				
	Clinic				

Personal Information			
HEIGHT		WEIGHT	
POSITION			

Covid-19 Information

Have you been diagnosed with Covid-19	Yes	No	Tested?	
Have you experienced Covid-19 symptoms like in the last 2 weeks	Yes	No		
Have you been in contact with someone who tested positive or has had symptoms in the last 2 weeks	Yes	No		
Have you travelled overseas in the last 2 weeks?	Yes	No	Where?	

Emergency Contacts	
NAME	
Relationship	
Phone Number	
NAME	
Relationship	
Phone Number	

Family History	
Has anyone in your family	*If Yes - Who?*
Died suddenly and unexpectedly (under 50 yrs old)	
Has significant cardiovascular disease (under 50 yrs old)	
Has been diagnosed with Marfan Syndrome	
Has been diagnosed with irregular heart rhythm	
Has been diagnosed with heart issues (cardiomyopathy, hypertrophic / dilated heart)	
Has connective tissue disorders?	
Has high or low blood pressure	
Other - Cancer, Diabetes, Liver, Lung, Kidney issues	

Personal Medical History			
Do you have allergies?	Y / N	To?	
		Meds?	
Do you have asthma?	Y / N	Meds?	
Do you have diabetes?	Y / N	Type?	
		Meds?	
Do you have epilepsy?	Y / N	Type?	
		Meds?	
Do you have heart problems	Y / N	Type?	
		Meds?	
Do you have headaches or Migraines	Y / N	When?	
		Meds?	
Do you ever faint / get dizzy / lightheaded during exercise?	Y / N	Type?	
	Y / N	Meds?	
Do you smoke?	Y / N	Quantity	
Do you use tobacco products?	Y / N	Explain	
Do you use recreational drugs?	Y / N	Type?	
		Frequency	

Medications			
Substance	Reason	Dosage	Prescribed by

Nutritional and Supplements History			
Do you use ephedrine / creatine / weight cutter?	Y / N	Explain?	

Do you use anabolic steroids / steroids	Y / N	Explain?	
Do you use other hormones?	Y / N	Explain?	

Concussion & Neurological History	
Questions	
Have you ever had a seizure?	
Have you ever been knocked out?	
Have you been diagnosed with migraines or headaches?	
Have you been diagnosed with ADD / ADHD / other learning Disability?	
Have you ever have numbness or tingling in your arms, hands, legs, or feet?	

Concussion History					
Date	***Sport***	***Review***	***Time to return***	***Still a problem?***	***Imaging / Hospital?***
1-					
2-					
3-					
4-					

Baseline Symptoms

Please score yourself on the following symptoms, based on **how YOU FEEL NOW**, ***only applicable if you have suffered a concussion recently***!					
	None Moderate Severe		None Moderate Severe		0 1 2 3 4 5 6
Headache	0 1 2 3 4 5 6	Sensitivity to Light	0 1 2 3 4 5 6	Trouble Falling Asleep	0 1 2 3 4 5 6
"Pressure In Head"	0 1 2 3 4 5 6	Sensitivity to Noise	0 1 2 3 4 5 6	More Emotional	0 1 2 3 4 5 6
Neck Pain	0 1 2 3 4 5 6	Feeling slowed down	0 1 2 3 4 5 6	Irritability	0 1 2 3 4 5 6
Nausea or Vomiting	0 1 2 3 4 5 6	Feeling like "in a fog"	0 1 2 3 4 5 6	Sadness	0 1 2 3 4 5 6
Dizziness	0 1 2 3 4 5 6	Don't Feel Right	0 1 2 3 4 5 6	Nervous or Anxious	0 1 2 3 4 5 6
Blurred Vision	0 1 2 3 4 5 6	Difficulty concentrating	0 1 2 3 4 5 6		
Balance Problems	0 1 2 3 4 5 6	Difficulty remembering	0 1 2 3 4 5 6		
Confusion	0 1 2 3 4 5 6	Drowsiness	0 1 2 3 4 5 6		

Do any of these get worse with physical activity?	
Do any of these get worse with mental activity?	

General Health			
Do you wear glasses?	Yes / No	Sport?	
Do you wear contacts?	Yes / No	Sport?	
Do you wear dentures, false teeth or oral braces?	Yes / No	Sport?	
Do you wear a mouth guard	Yes / No	Sport?	
Do you use any other sensory aids (hearing?)	Yes / No	Explain?	

Do you have any malfunctioning or missing senses	Yes / No	Explain?	
Do you have any missing organs?	Yes / No	Explain?	
Have you ever had mono?	Yes / No	When?	
Do you have endocrine or thyroid issues?	Yes / No	Explain?	
Have you ever been treated for a skin conditions?	Yes / No	Explain?	

Immunizations			
Are you immunizations up to date?	Yes	No	
Last Flu Shot			
Last Tetanus Shot			

Musculoskeletal Injury History

Any current injury?

Past Injury	***Side***	***Diagnosis***	***Treatment***	***Still an issue?***
Hand / Wrist	R / L			
Forearm	R / L			
Elbow	R / L			
Shoulder	R / L			
Chest	R / L			
Neck	R / L			
Back	R / L			
Hip	R / L			
Knee	R / L			
Ankle	R / L			
Other	R / L			

Confidentiality

I (guardian) certify that the information provided is accurate to the best of my knowledge. I also give permission to the team physiotherapist and athletic therapists, or other qualified personnel to have access to information provided here. I (guardian) give the medical team the right to provide first aid, assessment, and treatments thorugh the season. In the occasion of an emergency and the emergency contact cannot be contacted, I hereby consent to be given medical care by the physician or hospital as seen fit by the Medical Team

Release of Information

All information is to remain confidential and stored in a safe manner. I consent to have the medical team members discuss amongst themselves medical information about myself and injuries. I understand they will have to communicate with my team's coaching staff and team manager about my ability to play. I reserve the right to ask the Medical Team to limit what information is provided to the coaching staff.

Consent -

Athlete's Signature ______________________________

Athlete's Name ______________________________

Date (dd/mm/yyyy) ______________________________

Parent's / Legal Guardian Signature ______________________________

Parent's / Legal Guardian Name ______________________________