

**UNIVERSITY OF MANITOBA
BISON SPORTS 2005-2006
PRE-SEASON MEDICAL QUESTIONNAIRE**

To be completed by the athlete or parent/guardian

Last Name _____ First Name _____
 Address _____ City _____ Province _____
 Home Phone # _____ Postal Code _____ Date of Birth ____M/____D/____Y
 Health Care # _____ (6 digit # only) Province _____
 Family Doctor's Name _____ Date of Last Physical Exam ____M/____D/____Y

FOR EMERGENCY PLEASE NOTIFY:

Name _____ Relationship _____
 Address _____ Phone # _____

In the past, have you experienced...? (Please explain "YES" answers in the space provided)

Have you ever been hospitalized?	YES	NO
Have you ever had surgery?	YES	NO
Are you presently taking any medications or pills?	YES	NO
Are you presently taking any vitamins or supplements?	YES	NO
Do you have any allergies (medicine, insects, or food)?	YES	NO
Have you ever passed out during or after exercise?	YES	NO
Have you ever been dizzy during or after exercise?	YES	NO
Have you ever had chest pain during or after exercise?	YES	NO
Do you tire more quickly than your friends during exercise?	YES	NO
Have you ever had high blood pressure?	YES	NO
Have you ever been told that you have a heart murmur?	YES	NO
Have you ever had racing of your heart or skipped beats?	YES	NO
Has anyone in your family died of heart problems or a sudden death before age 50?	YES	NO
Do you have any skin problems (itching, rashes, etc.)?	YES	NO
Have you ever had heat or muscle cramps?	YES	NO
Have you ever been dizzy or passed out in the heat?	YES	NO
Do you have trouble breathing or do you cough during or after exercise?	YES	NO
Do you use any special equipment (i.e. pads, braces, neck rolls, mouth guards, etc.)?	YES	NO
Do you use any dental appliances?	YES	NO
Have you had any problems with your eyes or your vision?	YES	NO
Do you wear glasses or contacts or protective eyewear?	YES	NO
Have you had any other medical problems (i.e. mononucleosis, diabetes, asthma, etc.)?	YES	NO
Have you had a medical problem or injury since your last evaluation?	YES	NO
Have you had any unexplained weight change?	YES	NO
When was your last tetanus shot?	YES	NO
When was your last measles immunization?	YES	NO
Female athletes: Over the past year, did you miss or have irregular periods?	YES	NO

Explain "YES" answers: _____

(You may write on the reverse of this page)

HEAD INJURIES/CONCUSSIONS:			
Have you ever had seizure?		YES	NO
Have you ever had a head injury?		YES	NO
Have you ever had a concussion or been "knocked out", had your "bell rung", or been "dinged"?		YES	NO
If YES, please list: Total Number:			
<u>Dates</u>	<u>Activity at the time</u>	<u>Length of unconsciousness (minutes)</u>	<u>Length of time until full return to activity</u>
Did you have any persistent problems with:			
Memory?	YES NO	Dizziness?	YES NO Headaches? YES NO

NECK INJURIES/BURNERS/STINGERS:			
Have you ever had a neck injury? (i.e. strain, sprain, fracture, etc.?)		YES	NO
Have you ever had a stinger, burner or pinched nerve? (burning, numb feeling in shoulder or neck after a hit to the head, neck or shoulder)		YES	NO
If YES, please list: Total Number:			
<u>Dates:</u>	<u>Activity at the time</u>	<u>Length of time sensation/strength changes persisted</u>	

Check any of the areas that you have INJURED IN THE PAST and explain the injury below:							
Neck	Shoulder	Arm	Elbow	Forearm	Wrist	Hand	
Chest	Back	Hip	Thigh	Knee	Leg (shin/calf)	Ankle	Foot
<u>Year of Injury</u>	<u>Type of Injury</u>		<u>Side (Right/Left/Both)</u>		<u>Is it still a problem? (Y/N)</u>		
Do you have any incompletely healed injury? If YES, which injury?						YES	NO

I hereby certify the above information to be correct:	
Athlete's Signature: _____	Date _____
Parent / Guardian Signature: _____	Relationship _____

MEDICAL EXAMINATION

To be completed by a medical doctor

Athlete's Name _____

Height _____ Weight _____ Resting Pulse _____

Visual acuity (uncorrected) R ____ / ____ L ____ / ____ (corrected) R ____ / ____ L ____ / ____

Color blindness _____ EENT, thyroid _____ Teeth _____

CHEST _____

CARDIOVASCULAR _____

ABDOMEN (including hernias, testicles) _____

CNS _____ DTR'S _____ SKIN _____

MUSCULOSKELETAL (please note any evidence of prior injury, instability, or loss of flexibility)

Hand / wrist _____

Elbow _____

Shoulder _____

Neck / back _____

Hip / pelvis _____

Knee _____

Ankle / feet _____

ADDITIONAL COMMENTS / ABNORMAL FINDINGS _____

LABORATORY (if indicated) CBC _____

Urine _____

Others (as indicated):

X-rays (as indicated):

RECOMMENDATIONS re: PARTICIPATION

NOTES:

No restrictions (Contact / collision) _____

Limited Contact / impact _____

Non-contact _____

 Strenuous _____

 Moderate _____

 Non-strenuous _____

Needs further consultation / tests _____

Not fit _____

Recommendations prior to participation (i.e. rehabilitation) _____

** Please add any relevant information from this page to the Problem List/Current Treatments on the next page*

Examining Physician (Print Name): _____ Physician's Signature: _____

Date: _____

