A.B.J SCOTS

Football Alberta Medical Form

(Side "A" – Personal Information to be filled out by ***you!***)

Last Name:_____ First Name:_____ Date of Birth (dd/mm/yyyy):_____

Address:_____ City/Town:_____ Prov._____ Postal Code:_____

Home Phone Number:(____)_____ Email Address:_____ Date of Last Physical (dd/mm/yy): _____

Alberta Heath Care Number:_____ **NOTE: DO NOT RETURN FORM UNLESS THIS LINE IS FILLED OUT!!!!!**

Emergency Contact (Name):_____ Relationship (i.e. Father, Aunt):_____

Emergency Contact Phone Number: (____)_____ Emergency Contact Address:_____

Family Doctor's Name:_____ Family Doctor's Address:_____

Family Doctor's Phone Number: (____)_____ Family Doctor's City/Town:_____ Postal Code:_____

Answer all of the questions below by checking YES or NO

HAVE YOU EVER HAD OR DO YOU NOW HAVE

	Yes	No		Yes	No
Heat Stroke/Cramps	____	____	Irregular Heart Beats	____	____
Infectious Mononucleosis	____	____	High or low blood pressure	____	____
Scarlett or Rheumatic Fever	____	____	A heart murmer	____	____
Tonsillitis/Sinusitis	____	____	Ear or Hearing Trouble	____	____
Coughed up blood	____	____	Difficulties with vision	____	____
Asthma	____	____	Frequent or Severe Headaches	____	____
Severe tooth or gum troubles	____	____	Epilepsy or fits	____	____
Stomach Ulcers	____	____	Dizziness or fainting spells	____	____
Pneumonia or Tuberculosis	____	____	"Stingers" or "burners"	____	____
Anemia or low iron	____	____	A Concussion or been "knocked out"	____	____
Hepatitis or liver trouble	____	____	Loss of Memory	____	____
Hernia or rupture	____	____	Any mental illness	____	____
Piles or haemorrhoids	____	____	Motion sickness	____	____
Tumour or cancer	____	____	Smoked cigarettes	____	____
Used alcohol	____	____	Kidney stones or blood urine	____	____
Frequent or painful urination	____	____	Used non-prescription/street drugs	____	____
Sexually transmitted disease	____	____	Diabetes	____	____
Skin rashes	____	____	Allergies	____	____
Arthritis	____	____	Any other medical illness	____	____

	YES	NO
Have you been treated for an infectious disease in the last 12 months? If YES, which disease?_____	____	____
Have you ever had to stay in hospital overnight? If YES, what for? _____	____	____
Have you ever had any surgery? If YES, what for? _____	____	____
Have you ever had any broken bones? If YES, which bones? _____	____	____
Do you wear contact lenses or glasses? If YES, which do you play sports with? _____	____	____
Do you have an eye condition that requires a tinted visor while playing football? If YES, please attach note from doctor. _____	____	____
Have you seen a physiotherapist and/or chiropractor? If YES, what for? _____	____	____
Do you have any pins, plates or screws in your body from any bone or joint surgery? If YES, where?_____	____	____
Do you wear any dental appliances such as braces or a plate?	____	____

FAMILY HISTORY: Please circle any illnesses that have affected family members past or present.

Diabetes, Allergies, Arthritis, Neurological Disorders, Gout, Heart Disease, High Blood Pressure, High Cholesterol, Bleeding Problems, Kidney Disease, Mental Illness, Sickle Cell Anemia

	YES	No
Has anyone in your family died suddenly before the age of 40?	____	____

	YES	NO
ARE YOU TAKING ANY MEDICATIONS? If YES, please list._____	____	____
ARE YOU TAKING ANY SUPPLIMENTS? If YES, please list._____	____	____
DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? If YES, please list._____	____	____
DO YOU HAVE ANY OTHER ALLERGIES (i.e. bees)? If YES, please list._____	____	____

WHEN WERE YOUR IMMUNIZATIONS LAST UPDATED (Including Tetanus) (dd/mm/yyyy) _____

CHECK ANY OF THE AREAS THAT YOU HAVE INJURED IN THE PAST AND EXPLAIN THE INJURY BELOW:

Hand ____ Elbow ____ Neck____ Hip____ Shin/calf____ Wrist____ Knee____ Foot____

Arm____ Chest____ Thigh____ Ankle____ Forearm____ Shoulder____ Back____ Neck___

_____

_____