



Azorcan Europe Tour Confidential Medical History-2008

Name: _____ Date of Birth: day ____ month ____ year ____
Address: _____ City _____ Prov. _____ Pstl Cd. _____
Home Phone: _____
In case of Emergency Notify: _____ Relationship: _____
Address: _____ Phone: _____
Physician: _____ Physician Telephone: _____
Health Care No. _____

Immunizations up to date? _____ When was your last tetanus booster? _____
Last dentist visit _____ Do you use any dental appliances? _____
Handedness (left or right) _____

Do you have any allergies? Please list them below.

Are you taking any medications, medicines, or drugs? If yes please list them below.

Are you taking any vitamins or supplements? If yes please list them below.

Do you have any of the following heart conditions? Answer yes or no.

murmur? ____ heart disease? ____ Palpitation? ____ Heart racing or skipped beats? ____

Anyone under fifty years old in the family die of heart problems? ____

Do you have to stop when running a half-mile, twice around the track? _____

Have you ever passed out during or after exercise? _____ When? _____

Have you ever been dizzy or had chest pain during or after exercise? ____ When? _____

Have you had or do you have high blood pressure? _____

Asthma? Wheezing? Hay fever? _____

Have you ever had heat or muscle cramps? _____

Have you ever been dizzy or passed out in the heat? _____

Do you have problems breathing or cough during or after exercise? _____

Have you ever had a head injury? _____ Have you ever had a seizure? _____

Have you ever had a concussion? If yes list when, if you were unconscious, what activity you were doing and how many days the symptoms lasted.

Date: _____ Unconscious ? ___ During what activity _____ Symptoms lasted ___ days

Date: _____ Unconscious ? ___ During what activity _____ Symptoms lasted ___ days

Do you have persistent problems with (yes/no): Memory ___ Dizziness ___ Headaches ___

Have you ever had a neck injury? _____

Have you ever had a stinger, burner or pinched nerve? If yes list when, what activity you were doing and how many days the symptoms lasted.

Date: _____ During what activity _____ Symptoms lasted ___ days

Date: _____ During what activity _____ Symptoms lasted ___ days

Have you ever had trouble with;

Eyes (vision) _____ Do you use contacts? _____

Ears (hearing) _____

Kidneys (urine) _____

Hernias _____

Blood Type _____ x _____ x _____ (not essential)

Do you have any skin problems? (itching, rashes, acne) _____

Major medical illness (eg. Seizures, anemia, diabetes, arthritis, thyroid disease, bleeding disorders, hepatitis) _____

Are you wearing a medical alert bracelet? _____

If you have ever been hospitalized answer when and what it was for each time.

Date: _____ Illness: _____

Date: _____ Illness: _____

Have you ever had an operation or surgery? If so list each operation or surgery.

Date: _____ Operation: _____

Date: _____ Operation: _____

Have you ever had a fracture or broken bones? If yes list each injury.

Date: _____ Injury: _____

Date: _____ Injury: _____

Ever had a cast, splint, sling, cane or crutches? _____

Ever had an x-ray of any bone or joint? _____

Have you ever had a bad knee injury (ligaments or cartilage)? _____

Does your knee ever "give way" under you, "lock up" or swell ? _____

Have you ever dislocated or separated a shoulder? If yes list each injury.

Date: _____ Injury: _____

Date: _____ Injury: _____

Do you wear any special equipment (pads, braces) _____

Ever had an injury that caused you to miss a game or practice? _____

Do you have a current injury that is not yet fully healed? _____

ADDITIONAL HISTORY INFORMATION (any other medical problems?)

This form will be used to inform the team medical person or any other doctor of your medical history in the case of an emergency. The information provided above will be considered confidential.

Signature _____ Date: _____

A parent or guardian must sign the form for a minor. (under 18)