Azorcan Europe Tour

Confidential Medical History

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 gurdian must sign the form for a minor. (under 18)