

Bishop's University
MEDICAL HISTORY QUESTIONNAIRE

Please enclose this questionnaire with final payment and return before
(June 1st) Football School or **(August 1st) Basketball Camp**
Week 1 and/or Week 2

Athlete's Family name: _____ First name _____

Home Address: _____

City: _____ Province: _____ Postal Code _____

Date of Birth: ____/____/____ Health Insurance #: _____ / _____
Day / Month/Year Expiration (Yr / Mo)

Medical Background: (please check yes or no)

1. Have you had a medical examination in the past year? Yes No
2. Do you suffer from any of the following:
Diabetes Yes No Chest pains Yes No Fainting Yes No
Asthma Yes No High blood pressure Yes No
Epilepsy Yes No Dizzy spells Yes No
3. Do you suffer from either abdominal pain, recurrent headaches or frequent colds? Yes No
Specify: _____
4. Do you suffer from any allergies? Yes No
Specify: _____
5. Do you wear a medical alert bracelet? Yes No
Specify: _____
6. Are you taking any medication? Yes No
Specify: _____
7. Have you been hospitalized within the last year? Yes No
Specify: _____
8. Do you suffer from any physical problems or injuries?(i.e. knee, back arthritis, etc.) Yes No
Specify: _____
9. Do you have recurring dislocations? Yes No
Where? _____
10. Do you wear contact lenses? Yes No
11. Have you ever experienced a concussion or been "knocked out"? Yes No
If so, how many times? _____ Did you stay overnight in the hospital? Yes No

IN CASE OF EMERGENCY, please notify:

Name(s): _____	Relationship: _____
Address: _____	
Telephone: Day: _____	ext. _____ Cell: _____
Evening: _____	Cell: _____