NAIT OOKS Female Athlete Medical

Varsity Team:_____
Year of Eligibility: 1 2 3 4 5
(Entering into)

Last Name: _____ First Name: _____

Local Address: _____ City: _____ Prov.: _____ Postal Code:_____

Local Phone: ( ) _____ E-Mail: _____ Age:_____ D.O.B.:_____
Student No.: _____ Prov. Health Care #: _____ Prov: _____

Emergency Contact (local): _____ Relationship: _____

Emergency Contact (family): _____ Relationship: _____

Medications: Please list all prescribed and over-the-counter medications and supplements you are currently taking:
_____
_____
Do you have allergies? Yes / No If yes, please specify:_____

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason? If so, explain why below.		
2. Do you have any ongoing medical conditions? (infectious mononucleosis, diabetes, asthma, etc)		
3. Have you been advised to be on any medication on a regular basis? Identify medications in space below		
4. Do you use or have you ever used an inhaler?		
5. Are you now on, or have you ever been advised to be on any supplements on a regular basis? Identify in space below		
6. Within the last year have you had any illness or medical condition lasting longer than one week?		
7. Do you have, or have you ever had a skin infection? Identify below what infection and when		
8. Do you have any joint, bone, or muscle pain not associated to injury?		
9. Within the last year have you had an injury requiring you to miss more than one practice or game?		
10. Have you ever had surgery? Identify surgeries below		
11. When was your last tetanus shot?		
12. Within the last year, have you been admitted to hospital?		
13. Do you currently have an incompletely healed injury?		
14. Do you ever experience unexplained weight loss/gain?		
15. Are you satisfied with your current weight? If not, explain		

AS A RESULT OF PHYSICAL ACTIVITY	Yes	No
16. Do you ever experience coughing or wheezing during or after exercise?		
17. Do you ever experience frequent or severe headaches?		
18. Have you ever passed out or nearly passed out during or after exercise?		
19. Do you ever get lightheaded, dizzy or feel more short of breath than expected during exercise?		
20. Have you ever experienced heat exhaustion or heat stroke?		
21. Do you ever experience muscle cramps or abdominal pain with exercise?		
22. Have you ever had any broken/fractured bones, or dislocated joints? Identify below.		
23. Have you ever had a stress fracture?		
24. Have you ever had an injury that required x-rays, MRI, CT scan, injections, or a brace?		
25. Have you ever been tested for a bloodbourne pathogen? (ie HIV, Hep B or C). Please explain test results below.		
26a. Have you ever had a concussion, or hit to the head causing confusion, headache, memory problems?		
26b.If Yes, How many? When was the last one?		
27. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
29. Do you use any special equipment? (ie brace, pads, orthotics, etc)		
30. Do you have any problems with your eyes or vision?		
31. Do you wear glasses, contacts, or protective eyewear in practices or games?		
32. Do you use any dental equipment?		

Explain 'Yes' Answers From This Page Before Proceeding:

_____
_____
_____
_____
_____
_____

WOMENS HEALTH QUESTIONS (explain any and all YES answers)	Yes	No
32. How old were you when you had your first menstrual cycle?		
33. How many cycles do you usually have in a year?		
34. How long do your periods usually last?		
35. How many periods have you had in the last 12 months?		
36. Have you ever been treated for anemia?		
37. Do you take calcium supplements?		
38. Have you ever tried to lose weight by: i) vomiting ii) diuretics iii) laxatives iv) diet pills		
39. Have you ever been diagnosed with an eating disorder? (ie anorexia nervosa or bulimia nervosa)		
40. Do you have any questions regarding healthy ways to control your body weight		

HEART HEALTH QUESTIONS	Yes	No
41. Does your heart ever race or skip beats during exercise?		
42. Do you, or have you ever been told you have an irregular heartbeat?		
43. Do you, or have you ever been told you have a heart murmur?		
44. Has a doctor ever ordered testing for your heart? (Including ECG, EKG, ultrasound, etc.)		
45. Have you ever experienced heart palpitations (when you heart feels as if it is pounding/racing)		
46. Are you on any medications for a heart condition?		

Explain 'Yes' Answers From This Page Before Proceeding:

_____

_____

_____

_____

Please list and describe any injuries that you have had in the past **YEAR:**

Description	Treatment Received	Date of Injury	Current Status (playing/limited/out)	Current Care (y/n) Who?

Your pre-season medical will be collected and stored in a confidential manner. Information pertaining to clearance and/or restrictions will be shared only with those in the school administration who need to know. By signing this form, you are giving us permission to share information that may arise during the academic year that could impact sports participation, with those essential to the process of evaluation and future participation. This may include members of the NAIT Athletic Therapy Clinic, as well as your personal physician, team physicians, sports medicine physicians, athletic therapist, or physiotherapists. Specific medical information will not be discussed with non-healthcare professionals, but final clearance or disqualification decisions may be reviewed with school officials. We will attempt to maintain your privacy the best that we can during the pre-season screening and during the upcoming sports season.

Is there anything else you would like to discuss with the Nait Therapy Staff or a Sports Medicine Physician?	Yes	No

I hereby certify the above information to be correct.

Athlete Signature: _____Date:_____

If under 18 years of age,
Parent or Guardian signature: _____

Print Name: _____ Date:_____