UNIVERSITY OF TORONTO MISSISSAUGA

Department of Recreation, Athletics & Wellness

Varsity Athlete Medical Form

Date (YYYY/MM/DD):_____

Last Name:_____ First Name:_____

Birth Date (YYYY/MM/DD):_____ Gender: Male □ Female □

Sport:_____ Position:_____ Program:_____

Health Card Number:_____ Version Code:_____ Expiry:_____

UHIP Number:_____ Student Number:_____

Address:_____

City:_____ Province:_____ Postal Code:_____

Phone Number:_____ E-Mail Address:_____

Family Doctor		
Physician:		Practice Location:
City:	Province:	Phone:
Emergency Contact		
Name:		Home Phone:
Relationship:		Cell Phone:

Medical History

Allergies:_____

Medications/Supplements:_____

Special Dietary Needs/Restrictions:_____

Glasses or Contact Lenses: □ Yes □ No

Dental Appliances (Braces, Retainer, False Teeth etc.):_____

General Health – Do you currently or have previously had any of the following medical issues:					
Cardiovascular Issues:			Respiratory Issues:		
Blood Pressure (High/Low)	□ Yes	□ No	Asthma	□ Yes	□ No
Cholesterol (High/Low)	□ Yes	□ No	Shortness of Breath	□ Yes	□ No
Heart Palpitations/Murmur	□ Yes	□ No	Bronchitis/Pneumonia	□ Yes	□ No
Heart Disease or Stroke	□ Yes	□ No	Chest Pains	□ Yes	□ No
Implanted Pacemaker/Device	□ Yes	□ No	Smoke Cigarettes/Dip/Chew	□ Yes	□ No
If Yes, Please explain:					

General Health – Do you currently or have previously had any of the following medical issues:					
Hepatitis A,B or C	□ Yes	□ No	Sudden Falls (legs giving out)	□ Yes	□ No
HIV/AIDS	□ Yes	□ No	Bleeding Disorders/Clots	□ Yes	□ No
Tuberculosis	□ Yes	□ No	ADHD/Learning Disabilities	□ Yes	□ No
Cancer or Tumor	□ Yes	□ No	Convulsions/Seizures/Epilepsy	□ Yes	□ No
Mononucleosis	□ Yes	□ No	Endocrine or Thyroid Issues	□ Yes	□ No
Anemia	□ Yes	□ No	Diabetes	□ Yes	□ No
Headaches/Migraines	□ Yes	□ No	Dizziness/Fainting	□ Yes	□ No
Double Vision	□ Yes	□ No	Skin Conditions	□ Yes	□ No
Difficulty Swallowing	□ Yes	□ No	Difficulty Speaking	□ Yes	□ No
Malfunctioning or Missing Organs (Kidneys, Liver, Spleen, Bowel etc.)				□ Yes	□ No
Malfunctioning or Missing Senses (Vision, Hearing, Taste or Smell)				□ Yes	□ No
If Yes, Please explain:					

Previous Medical History		
Any Recent Surgeries, Fractures, Separations or Dislocations?	□ Yes	□ No
Previous Facial or Dental Injuries?	□ Yes	□ No
Previous Neck or Back Injuries?	□ Yes	□ No
Previous Shoulder or Chest Injuries?	□ Yes	□ No
Previous Arm, Elbow, Forearm, Wrist or Hand Injuries?	□ Yes	□ No
Previous Hip or Groin Injuries?	□ Yes	□ No
Previous Knee Injuries?	□ Yes	□ No
Previous Leg Injuries?	□ Yes	□ No
Previous Ankle or Foot Injuries?	□ Yes	□ No
Previous Motor Vehicle Accidents?	□ Yes	□ No
If Yes, Please explain:		

Family Health History – Has any member of your immediate family:		
Died suddenly or unexpectedly (under the age of 50)?	□ Yes	□ No
Died suddenly during physical activity?	□ Yes	□ No
Had significant cardiovascular disease under 50 years?	□ Yes	□ No
Had heart surgery?	□ Yes	□ No
Been diagnosed with Marfan's Syndrome?	□ Yes	□ No
Been diagnosed with irregular heart rhythm?	□ Yes	□ No
Been diagnosed with cardiomyopathy?	□ Yes	□ No
Been diagnosed with hypertrophic or dilated heart?	□ Yes	□ No
Had inherited heart rhythm problem (long QT syndrome etc.)?	□ Yes	□ No
Had Heart Disease or High Blood Pressure?	□ Yes	□ No
Had any Bleeding Disorders or Sickle Cell Disease?	□ Yes	□ No
Had any other Disease or Disorder (Cancer, Liver, Lung, Kidney etc.)?	□ Yes	□ No
If Yes, Please explain:		

Head Injury History															
Do you have any history of diagnosed concussions? If Yes, how many and what were the approximate dates:														□ Yes	□ No
Do you have any suspected undiagnosed concussions or had your bell rung (i.e. been knocked out, experienced headache, dizziness, nausea, memory loss, blurred vision, ringing in the ears following a hit to the head or whipping of the neck)? If Yes, how many and what were the approximate dates:														□ Yes	□ No
Have you ever been sent to the hospital as a result of a head or neck injury? If Yes, Please explain:														□ Yes	□ No
Do you get frequent headaches? How Often?														□ Yes	□ No
Symptom Scores – Score these symptoms based on how you currently feel															
	Mild			Moderate			Severe		Mild			Moderate			Severe
	0	1	2	3	4	5	6		0	1	2	3	4	5	6
Headache								"Don't feel right"							
"Pressure in head"								Difficulty concentrating							
Neck Pain								Difficulty remembering							
Nausea or vomiting								Fatigue or low energy							
Dizziness								Confusion							
Blurred vision								Drowsiness							
Balance problems								More emotional							
Sensitivity to light								Irritability							
Sensitivity to noise								Sadness							
Feeling slowed down								Nervous or anxious							
Feeling like "in a fog"								Trouble falling asleep							
Do symptoms get worse with physical activity?														□ Yes	□ No
Do symptoms get worse with mental activity?														□ Yes	□ No
Lifestyle & Health Review															
Have you had any recent weight changes? □ No □ Yes If Yes: _____lbs.														□ Gain	□ Loss
Do you have any dietary problems or eating disorders?														□ No	□ Yes
Have you ever tried to control your weight with any of the following? If Yes, Indicate Below □ Exercise □ Fasting □ Vomiting □ Laxatives □ Diuretics □ Diet Pills □ Other: _____														□ No	□ Yes
Do you use Protein, Creatine, or Pre-Workout?														□ No	□ Yes
Do you use Ephedrine or any other energy boosters/weight cutters?														□ No	□ Yes
Do you or have you previously used any Performance Enhancing Drugs?														□ No	□ Yes
Do you take any herbal, homeopathic, or natural remedies?														□ No	□ Yes
Do you use Energy Drinks (Red Bull, Monster etc.)?														□ No	□ Yes
Do you take any other Supplements?														□ No	□ Yes
Do you use Tobacco (any form)? If yes, how much per day?														□ No	□ Yes
Do you use Marijuana (any form) or other Recreational Drugs?														□ No	□ Yes
Do you drink Alcohol? If yes, how much per week?														□ No	□ Yes
Do you often have trouble sleeping?														□ No	□ Yes
How many hours do you train for your sport per week? _____ Hours															
How many hours do you train beyond normal team training (practices, workouts etc.) per week? _____ Hours															
If Yes, Please explain:															

Immunization History - Provide year of last immunized if known:				
Tetanus/Diphtheria		□ Unsure	□ No	□ Yes _____
Hepatitis A		□ Unsure	□ No	□ Yes _____
Hepatitis B		□ Unsure	□ No	□ Yes _____
HPV Vaccine		□ Unsure	□ No	□ Yes _____
Meningitis		□ Unsure	□ No	□ Yes _____
Chicken Pox		□ Unsure	□ No	□ Yes _____
Measles/Mumps/Rubella		□ Unsure	□ No	□ Yes _____
Mental Health Screening				
General Anxiety Disorder (GAD-7)				
Over the last two weeks, how often have you been bothered by the following problems?	Not at all **1**	Several days **2**	Over half the days **3**	Nearly every day **4**
1) Feeling nervous, anxious or on edge				
2) Not being able to stop or control worrying				
3) Worrying too much about different things				
4) Trouble relaxing				
5) Being so restless that it's hard to sit still				
6) Becoming easily annoyed or irritable				
7) Feeling afraid as if something awful might happen				
Add the score for each column				
Total Score (Add your column scores, value of 1-4 per column selected) =				
If you checked off any problems, how difficult have these made for you to do your homework, take care of things at home, or get along with other people? Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult_____				
Patient Health Questionnaire (PHQ – 9)				
Over the last two weeks, how often have you been bothered by the following problems?	Not at all **1**	Several days **2**	Over half the days **3**	Nearly every day **4**
1) Little interest or pleasure in doing things				
2) Feeling down, depressed, or hopeless				
3) Trouble falling or staying asleep, or sleeping too much				
4) Feeling tired or having little energy				
5) Poor appetite or overeating				
6) Feeling bad about yourself, or that you are a failure, or have let yourself or your family down				
7) Trouble concentrating on things, such as reading the newspaper or watching TV				
8) Moving or speaking so slowly that others could have noticed. Or the opposite; being fidgety or restless that you have been moving around more than usual				
9) Thoughts that you would be better off dead or of hurting yourself in some way				
Total Score (Add your column scores, value of 1-4 per column selected) =				
If you checked off any problems, how difficult have these made for you to do your homework, take care of things at home, or get along with other people? Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult_____				

Gynecological Health History:		
Have your periods been regular? In No, Please Explain Below	□ Yes	□ No
How many days do your periods last? _____ Days		
Normal duration between periods? _____ Days		
Do you have excessive pain or cramps during your period?	□ Yes	□ No
Are you currently on a form of birth control (pill, patch, injection, IUD)? If Yes, Which kind?	□ Yes	□ No
Pregnancy (Past or Present)? ☐ No ☐ Yes If Yes: Number (Including miscarriages)? _____		

Athlete Consent

I hereby certify that the above information is an accurate and complete record of my current medical status, and that I will notify the Rehabilitation & Fitness Specialist (Athletic Therapist) of any changes in my health (illness/injury) that occurs during the season. I may require further evaluation by the University of Toronto Mississauga medical staff prior to any participation (including practices, training camps).

As a member of a Varsity team at the University of Toronto Mississauga, I authorize the professional staff of the Athletic Therapy Centre to release personal and medical information to the UTM Eagles Sport Medicine Team (Athletic Therapist, Student Athletic Therapists, Health and Counselling Center and Sports Medicine Physician), and the Integrated Support Network (UTM Athletics Administration and Coaches). This is limited to information pertaining to my health and physical condition, including injuries and their treatment progress, as it relates to my participation as a member of the team. Information will also be shared in the case of an emergency requiring immediate medical attention. Information will only be shared with the listed parties on a need-to-know basis in order to perform their duties and will only be used or disclosed for the purposes for which it was collected, except with patient consent or as required by law.

I understand that this general permission can be revoked by specific request to the Athletic Therapist. In the event of a medical emergency, I hereby authorize the paramedics, physicians and nursing staff to undertake any examination, investigation and necessary treatment for me.

Signature of Athlete: _____

Signature of Parent or Guardian: (If athlete is under 18 years old): _____

Date: _____/_____/_____
D M Y

Note: This consent expires one calendar year from the date signed above.