



UPEI PANTHERS MEDICAL HISTORY QUESTIONNAIRE

(to be completed by any new athlete to UPEI or returning after an absence of 2 or more years)

This side (medical history, allergies, past medical history and current medications) is to be completed by the STUDENT and the other sections by a PHYSICIAN. Complete this side and bring it with you to the Doctor's Office.

Name: _____

DOB: (M/D/Y): _____ (last) / _____ (first) / _____ (middle) Male: ___ Female ___ Student #: _____

Sport: _____ Coach: _____

Personal Health Number: _____ Family Doctor: _____

In event of an emergency, please notify: _____

Relationship to you: _____ Home phone: _____

Work phone: _____ Cell phone: _____

MEDICAL HISTORY: Check if you currently have OR have had in the past any of the following:

(C=current problem P=past problem)

	C	P		C	P		C	P		C	P
Frequent colds			Measles			Whooping Cough			Frequent Constipation		
Influenza			Mumps			Scarlet Fever			Frequent Diarrhea		
Bronchitis			Poliomyelitis			Kidney Disease			Frequent Urination		
Pneumonia			Appendicitis			Rheumatic Fever			Painful Urination		
Tuberculosis			Jaundice			Skin Disease			Frequent Vomiting		
Chickenpox			Hernia			Heart Murmur			Frequent Nosebleeds		
Diphtheria			Diabetes			Palpitations			Bone & Joint Disease		
Blackouts			Seizures			Back Problems			Drug or Alcohol Problem		
						Blurred Vision			Shortness of Breath		

Other: (please specify): _____

Do you smoke? If so, specify how many cigarettes per day? _____

Family health problems (ie: diabetes, stroke, etc): _____

Any additional information: _____

ALLERGIES: Include description of your usual allergic reaction

Medications: _____

Environment: _____

Other: _____

PAST MEDICAL HISTORY: Specify

Hospitalizations: _____

Surgery: _____

Fractures: _____ Sprains: _____

Dislocations: _____

Concussion (specify date): _____

CURRENT MEDICATIONS: List any medications (prescription and over the counter) that you are presently using, including frequency of use: _____

Student signature: _____ Date: _____

NOTE: Read & sign "Assumption of Risk" and "Consent to Receive Medical Care" on bottom of reverse side.

