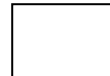
Alert 

MEDICAL QUESTIONNAIRE

NAME:

Date of Birth:

Do you suffer from any of the following conditions?

If yes please give details overleaf.

Address:

Tel No (H): (W):
Mobile:
Email:

Condition		
Hay fever, Asthma or other chest diseases?	No	Yes
Diabetes?	No	Yes
Thyroid gland problems?	No	Yes
Sickle Cell Anaemia?	No	Yes
Epilepsy?	No	Yes
Migraine?	No	Yes
Blood Pressure Problems (high or low)?	No	Yes
Enlarged heart, irregular pulse or heart murmur?	No	Yes
Has anyone in your family died suddenly from heart disease?	No	Yes
Facial herpes (Cold sores, Scrum pox)?	No	Yes
Other skin diseases (eg Psoriasis, Eczema)?	No	Yes
Do you only have one testis or only one kidney?	No	Yes
Have you ever had a retinal detachment?	No	Yes
Do you wear glasses or contact lenses? If so what type and do you have spares?	No	Yes
Do you have any ear or hearing problems?	No	Yes
Any illness or disease not mentioned above?	No	Yes
Do you wear a mouthguard?	No	Yes

Next of Kin:

Tel No (H): (W)
Mob:

Own G.P.

Tel No:

Allergies

Are you allergic to any of the following?

Allergy		
Penicillin?	No	Yes
Aspirin?	No	Yes
Any other drugs?	No	Yes
Iodine?	No	Yes
Vaccines or anasthetics?	No	Yes
Elastoplast?	No	Yes
Any food allergies (eg peanuts)?	No	Yes

Head Injuries: Have you **ever** had a head injury which caused loss of consciousness, loss of memory, vomiting or admission to hospital? If so, when?

Medication: State the names of any medicines or drugs that you take (including creatine, other supplements and non prescription medicines)

Have you had a corticosteroid (cortisone) injection in the past year? If so, state the site of the injection and date.

Date of last tetanus vaccination:
Date of Hepatitis B Vaccination (if applicable):

Injuries and operations: Identify the sites of any operations or injuries that have prevented you from playing for more than **three weeks** and recurrent injuries including any joints that you always tape.

L hand	No	Yes
R hand	No	Yes
L wrist	No	Yes
R wrist	No	Yes
L elbow	No	Yes
R elbow	No	Yes
L arm	No	Yes
R arm	No	Yes
L shoulder	No	Yes
R shoulder	No	Yes
L a/c joint	No	Yes
R a/c joint	No	Yes
Head injury	No	Yes
Neck injury	No	Yes
Back injury	No	Yes

Chest /ribs	No	Yes
Nasal or facial bones	No	Yes
Jaw	No	Yes
Dental injuries	No	Yes
Ears	No	Yes
Abdomen	No	Yes
Pelvic injuries	No	Yes
Hernia	No	Yes
Genitalia	No	Yes
L hip	No	Yes
R hip	No	Yes
L hamstring	No	Yes
R hamstring	No	Yes
L thigh	No	Yes
R thigh	No	Yes

L groin	No	Yes
R groin	No	Yes
L knee	No	Yes
R knee	No	Yes
L shin	No	Yes
R shin	No	Yes
L calf	No	Yes
R calf	No	Yes
L Achilles	No	Yes
R Achilles	No	Yes
L foot/toes	No	Yes
R foot/toes	No	Yes

Do you use corrective orthotics?	**No Yes**

Details from Questions overleaf and above ticked 'yes'	
IMPORTANT: If an operation, state hospital and surgeon: **DATE:**	

This is a true record of all my illnesses and injuries

Signed: .... Date: ....