RUGBY ALBERTA
HEALTH QUESTIONNAIRE

NAME:____ TEL:

ADDRESS:
CITY/POSTAL CODE:

DATE OF BIRTH:________/________/_______/

HEALTH CARE #:___________________________________ THIS IS IMPORTANT!!!

CONTACT PERSONS:
NAME:_________________________TEL:____________RELATION:
NAME:_________________________TEL:____________RELATION:

FAMILY PHYSICIAN:________________________________TEL:

PLEASE COMPLETE THE QUESTIONNAIRE WITH AS MUCH ACCURACY AS POSSIBLE:

Family History: Please identify any health problems that have occurred in your immediate family. Circle the appropriate response.

Y N Has anyone in your family (under age 50) died suddenly?
Y N High blood pressure
Y N Heart trouble
Y N Cancer or tumour
Y N Migraine or headaches
Y N Emotional problems
Y N Allergies/asthma
Y N Anaemia
Y N Diabetes
Y N Epilepsy
Y N Kidney/bladder disorder
Y N Stomach disorder
Y N Genetic disorder

Specify:

Do you at the present time experience:

Y N Difficulties with your eyes or vision?
Y N Difficulties with your nose or throat?
Y N Problems with hearing?
Y N Headaches, dizziness, weakness, fainting, any problems with co-ordination or balance?
Y N Numbness in any part of the body?
Y N Any tendency to shake or tremble?
Y N Cough, shortness of breath, chest pain or palpitations?
Y N Poor appetite, vomiting, abdominal pain, abnormal bowel habits?
Y N Any symptoms referable to the muscles, bones or joints, i.e., stiffness, swelling, pain?
Y N Any problems with the skin such as sores, rashes, itchy or burning sensations, etc.?
Y N Other symptoms? (specify on the chart at the end)

Have you ever had, or been told you had, or consulted a physician for:

Y N Diabetes, goitre or any other disease of the glands (eg., mononucleosis)?
If yes, when:

Y N Epilepsy?

Y N Nervous disorder or any disease of the brain or nervous system?

Y N Heart trouble or rheumatic fever?

Y N Varicose veins, phlebitis, hemorrhoids?

Y N Any tendency of the blood toward easy bruising or bleeding ?

Y N Tuberculosis, asthma or any lung disease or respiratory disorder?

Y N Ulcers or any disease of the stomach, intestines, liver or gallbladder?

Y N Sugar, albumin or blood in the urine or any disease of the kidneys?

Y N Arthritis, rheumatism or any injury or disease of the bones, peripheral joints, back or spine?

Y N Hernia or any disease of the muscles or skin?

Y N Cancer, tumour or growth of any kind?

Y N Have you ever had a head injury causing severe dizziness, loss of memory, vomiting, unconsciousness or requiring medical attention or hospitalization?
If yes, when:

Heat Disorder:

Y N Have you ever had trouble with dehydration?

Y N Have you ever had heat stroke?

Y N If yes, were you hospitalized?

Y N Other heat disorder? (specify at the end)

Y N Has your weight changed in the last year? How much?

Y N Any explanation for this change? Specify:

Y N Are you more thirsty than usual lately?

Drug, Food Supplements and Miscellaneous Agents:

Y N Are you taking any medications at present? Specify:

Y N Are you taking any vitamins at present? Specify:

Y N Are you taking any stimulants? Specify?

Y N Are you taking any anabolic agents? Specify:

Y N Are you taking any sleeping pills? Specify:

Y N Are you taking any other prescription drugs? Specify:

Y N Are you taking any non-prescription drugs not listed above?
Specify:

Y N Do you smoke? If yes, how much a day?

Y N Do you drink alcoholic beverages? If yes, how much per week?

Y N Have you ever been advised for medical reasons not to participate in sport for any period?

Y N Do you wear glasses for sports?

Y N Do you wear contact lenses for sports? If yes, are they soft____ or hard____?