WHL
Initial Entry Medical Form

PART A: PERSONAL INFORMATION

DATE: MM/DD/YYYY	TEAM:	
LAST NAME:	FIRST NAME:	
HOME PHONE:	CELL PHONE:	EMAIL:
HOME ADDRESS: STREET	CITY	PROV POSTAL CODE
HEALTH CARD NUMBER:	PROV./COMPANY:	DOB: MM/DD/YYYY
FAMILY PHYSICIAN:	PHYSICIAN PHONE:	
EMERGENCY CONTACT INFORMATION:		
LAST NAME:	FIRST NAME:	RELATIONSHIP:
HOME PHONE:	CELL PHONE:	EMAIL:
ADDRESS: STREET	CITY	PROV POSTAL CODE

PART B: MEDICATIONS AND ALLERGIES

Medications: List all of the medications, including prescription & over-the-counter medicines, and supplements that you are currently taking:

MEDICATIONS:	SUPPLEMENTS:
1)	1)
2)	2)
3)	3)
4)	4)
5)	5)

Do you have any allergies? ☐ Yes ☐ No If yes, please list specific allergies and reactions below.

☐ Medicines ☐ Pollens/Environmental ☐ Food (Gluten, Lactose, etc) ☐ Stinging Insects (Bees etc)

LIST ALLERGIES:	DESCRIBE REACTION:
1)	
2)	
3)	
4)	
5)	

FOR TEAM USE:

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PART C: MEDICAL QUESTIONNAIRE

Explain "Yes" answers in the space provided. Circle questions you don't know the answers to.

QUESTIONS	YES	NO	COMMENTS
GENERAL HEALTH			
Do you currently have any active medical issues?			
Do you have a chronic or recurrent medical condition?			
Have you missed any games this year for injuries/illness?			
Were you born without or are you missing a kidney, an eye, a testicle, your spleen, or any other organs?			
Have you ever had any illness, dysfunction or injury to any organ?			
Have you ever been hospitalized overnight? If YES, What for?			
Have you ever had surgery? If YES, what for?			
Have you had any cysts, tumours or growths removed?			
Do you have diabetes?			
Have you smoked cigarettes or used chewing tobacco?			
Have you drank alcohol?			
Have you used any illegal or other drugs?			
Have you ever taken anabolic steroids or used any other performance supplement?			
Have you ever become ill while exercising in the heat or had heat stroke/ cramps?			
Do you get frequent muscle cramps when exercising?			
RESPIRATORY SYSTEM			
Do you suffer from frequent respiratory infections including sinusitis?			
Do you have asthma, breathing problems or cough during exercise or on ice?			
Have you ever used an inhaler or taken asthma medicine?			
VISUAL SYSTEM			
Do you wear glasses, contacts, or had an eye injury or LASIK surgery?			
GASTROINTESTINAL SYSTEM			
Have you any problems with your stomach / intestines / liver / hemorrhoids?			
Have you had any stomach ulcers or gastrointestinal bleeding?			
Do you have any dietary issues such as gluten or lactose intolerance?			
Any other dietary concerns?			
INFECTIOUS DISEASES			
Have you been treated for an infectious disease in the past 12 months?			
Have you or anyone in your immediate family tested positive for or been treated for COVID-19? (please provide date/location of test)			
Have you had a severe viral infection in the last month?			
Have you had Mononucleosis?			
Have you ever had an HIV test? When?			
Have you had a herpes or MRSA skin infection?			
IMMUNIZATION HISTORY			
Did you complete your scheduled childhood immunizations? If Yes, please provide a copy of your immunization record. If No, please provide a copy of the record of all vaccinations received and list on this form all missing immunizations.			
Have you had any of the following diseases (check which apply): ☐ Measles ☐ Mumps ☐ Chicken Pox or ☐ None of these diseases ☐ COVID-19 ☐ Meningitis			Have you had the following immunizations: ☐ Influenza (most recent year _____) ☐ Hepatitis A ☐ Hepatitis B ☐ Chicken Pox ☐ Johnson + Johnson Single Dose ☐ Meningitis ☐ COVID-19 Vaccine 1 ☐ COVID-19 Vaccine 2
EAR/NOSE/THROAT			
Do you have a dental appliance? (Braces, bridge, false teeth, plate, etc)			
Do you have any hearing problems? (Hearing loss, ringing in ears, etc)			
SKIN			
Do you have any skin problems? (Rashes, itching, acne, fungus, etc)			
GENITOURINARY SYSTEM			
Have you had any kidney, bladder, or testicle problems?			
Have you had any sexually transmitted infections?			
Do you have groin pain or a painful bulge or hernia in the groin area?			
Have you had a sports hernia?			

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QUESTIONS	YES	NO	COMMENTS
MENTAL HEALTH			
Any treatment in the past for anxiety, depression, sleep, or fear of flying?			
Do you feel stressed out or under a lot of pressure?			
Do you ever feel sad, hopeless, depressed, or anxious?			
Do you have a racing mind or difficulty sleeping or falling asleep after games?			
Have you ever seen a sports psychologist for performance related issues? If so, who and when?			
BLOOD DISORDERS			
Do you have any issues with anemia or low iron?			
Do you have sickle cell trait or any other blood disease?			
Have you had any abnormal bruising, bleeding or blood clots?			
CARDIOVASCULAR SYSTEM			
Have you ever had blood pressure problems?			
Have you ever passed out or nearly passed out DURING or AFTER exercise?			
Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			
Does your heart ever race or skip beats (irregular beats) during exercise?			
Do you fatigue or get short of breath more quickly than your teammates?			
Do you get lightheaded or feel more short of breath than expected during exercise?			
Has a doctor ever ordered a test for your heart? (For example, ECG/EKG or an echocardiogram)			
Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ Kawasaki disease ☐ A heart murmur ☐ A heart infection (eg rheumatic fever, pericarditis) ☐ Other: _____			
Have you been advised by a physician to take antibiotics prior to dental treatment?			
Have you ever had an unexplained seizure?			
NEUROLOGICAL SYSTEM			
Do you have severe or frequent headaches? Any history of migraines?			
Do you have headaches with exercise?			
Have you ever had a 'stinger' or 'burner'?			
Have you ever had numbness, tingling or weakness in your arms or legs after being hit or falling?			
Have you ever had a convulsion or seizure?			
Have you ever been diagnosed with ADD/ADHD or any learning disorder?			
CONCUSSION			
Have you ever had injuries to the head, face or spine (excluding minor lacerations)?			
Any ImPACT Computer baseline testing? (If yes, specify date in comments)			
At times players may experience symptoms of a concussion even if a concussion is not diagnosed. NOT including any times where a concussion was diagnosed, have you at any other times experienced the following symptoms (circle symptoms experienced): Headache "Pressure In Head" Neck Pain Nausea or Vomiting Dizziness Blurred Vision Balance Problems Sensitivity to Light Sensitivity to Noise Feeling slowed down Feeling like "in a fog" Don't Feel Right Difficulty concentrating Difficulty remembering Excessive Fatigue Confusion Drowsiness Trouble Falling Asleep More Emotional Irritability Sadness Nervous or Anxious			
Have you ever had a concussion, a head injury or been knocked out? If yes, complete the following:			

1	RECOVERY TIME	IMPACT TESTING?	BRIEF DESCRIPTION OF EVENT	ADDITIONAL COMMENTS
YEAR	TIME OFF SPORT?	CT or MRI ?	SYMPTOMS EXPERIENCED (INCLUDING ANY POST-CONCUSSION PROBLEMS)	
2	RECOVERY TIME	IMPACT TESTING?	BRIEF DESCRIPTION OF EVENT	ADDITIONAL COMMENTS
YEAR	TIME OFF SPORT?	CT or MRI ?	SYMPTOMS EXPERIENCED (INCLUDING ANY POST-CONCUSSION PROBLEMS)	
3	RECOVERY TIME	IMPACT TESTING?	BRIEF DESCRIPTION OF EVENT	ADDITIONAL COMMENTS
YEAR	TIME OFF SPORT?	CT or MRI ?	SYMPTOMS EXPERIENCED (INCLUDING ANY POST-CONCUSSION PROBLEMS)	
4	RECOVERY TIME	IMPACT TESTING?	BRIEF DESCRIPTION OF EVENT	ADDITIONAL COMMENTS
YEAR	TIME OFF SPORT?	CT or MRI ?	SYMPTOMS EXPERIENCED (INCLUDING ANY POST-CONCUSSION PROBLEMS)	

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QUESTIONS	YES	NO	COMMENTS
ORTHOPEDIC SYSTEM			
Do any of your joints become painful, swollen, feel warm, or look red?			
Do you have any history of juvenile arthritis, muscular disease or connective tissue disease?			
Do you have any birth defects?			
Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?			
Do you have a bone, muscle, or joint injury that bothers you?			
Have you ever had any broken or fractured bones or dislocated joints?			
Have you ever had a stress fracture?			
Do you have pins, plates or any screws from any bone/joint surgery?			
Have you ever had an injury that required x-rays, MRI, CT scan, injections, a brace, a cast, or crutches?			
Have you seen a physiotherapist/chiropractor for any treatments in the past? For what?			
Do you regularly use a brace, orthotics, or other assistive device?			
Explain any yes answers above for the body part affected:			
Hand			
Elbow			
Neck			
Hip			
Shin/Calf			
Wrist			
Knee			
Foot			
Arm			
Chest			
Thigh			
Ankle			
Forearm			
Shoulder			
Back			

PART D: FAMILY HISTORY

To be completed by parent or guardian - signature required on Declaration Form

QUESTIONS	YES	NO	COMMENTS
Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?			
Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?			
Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?			
Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?			
Has anyone in your family had any of these illnesses? (If YES, circle the illness and provide details) Asthma, Diabetes, Allergies, Arthritis, Neurological Disorders, Seizures, Mental Illness including depression or anxiety, Gout, Heart Disease, High Blood Pressure, High Cholesterol, Stroke, Bleeding Problems, Kidney Disease, Sickle Cell Anemia, Alcohol or drug dependency			
Has a doctor ever told you, your son, or family member that they are at risk for any disease / condition?			

PART E: SUMMARY

QUESTIONS	YES	NO	COMMENTS
Do you currently have or have you ever had any injury, illness or medical condition not previously noted?			
Are you currently under a physician's care for any injury, illness or medical condition not previously noted?			
Have you ever been told by a physician to restrict your athletic activity or not participate in sports?			
Are you aware of any reason why you should not be allowed to participate in athletics at this time?			
Do you have any concerns that you would like to discuss privately with a doctor?			