



**Pre-Participation Medical Questionnaire
Team Canada Volleyball
Centralized Training**

**This form should be completed by the athlete and presented to
the physician during his/her medical exam.**

Player I.D. _____

Section A

Last Name: _____ First Name: _____

Address: _____ City: _____ Province: _____

Home Phone#(____) _____ Postal Code: _____

Health Care # _____ Province: _____

In Case of Emergency Notify: 1)Name: _____ Relation: _____

Address: _____ Phone: _____

2)Name: _____ Relation: _____

Address: _____ Phone: _____

Family Physician's Name: _____ Date of last Physical: _____

Physician's address and phone number: _____

Insurance Policy information: _____

Please circle "Y" or "N" for questions listed below

YES NO

Explain "Yes" answers in space provided

1. Have you ever been hospitalized?..... Y N
(List _____)

2. Are you presently taking any prescribed medications or pills?..... Y N
(*eg. Inhalers, insulin, anti inflammatories, antibiotics etc.*)
(List _____)

3. Do you take any vitamins, supplements or other over the counter medications?
(*eg. Herbs, protein powders, creatine supplement, iron supplement, steroids etc.*).... Y N
(List and reason for use (*weight loss, performance enhancement, increase muscle mass, illness prevention etc*) _____)

4. Are you allergic to any medication?
(*eg. aspirin, sulfa, penicillin etc.*)..... Y N
(List _____)

5. Have you ever been dizzy during or after exercise?..... Y N

6. Have you ever fainted during or after exercise?..... Y N
7. Do you tire quickly during exercise?..... Y N
8. Have you ever had high blood pressure?..... Y N
9. Have you ever been diagnosed with a heart condition eg. murmur?..... Y N
10. Have you ever had racing of your heart or skipped heartbeats?..... Y N
11. Has anyone in your family died of heart related problems or sudden death before the age of 50?..... Y N
12. Have you ever had skin problems?(*eg. rashes, itching,warts etc.*)..... Y N
(List _____)
13. Have you ever had heat or muscle cramps?..... Y N
14. Have you ever been dizzy or fainted in the heat?..... Y N
15. Do you have trouble breathing or cough during or after activity?..... Y N
16. Do you use any special equipment while practicing or competing?
(*eg. ankle brace, knee braces, orthotics, neoprene sleeve*)..... Y N
(List _____)
17. Do you have dental appliances permanent or removable?
(*eg. braces, mouth guard etc*)..... Y N
(List _____)
18. Have you had or do you have any problems with your eyes or vision?..... Y N
19. Do you wear glasses or contacts or protective eyewear while practicing or competing?..... Y N
20. Have you had or currently have any other medical problems?
(*eg. Infectious mononucleosis, diabetes, ulcers, pneumonia etc*)..... Y N
(List _____)
21. Do you have any congenital abnormalities?..... Y N
(List _____)
22. Have you ever been diagnosed as having a growth disorder?
(*eg. Osgood Schlatter's*)..... Y N
(List _____)
23. Do you have any food or environmental allergies?
(*eg. Peanuts, bee stings etc*) Y N
(List _____)
24. Have you had a significant weight loss or gain in the past year? _____

Section B

Height(centimetres): _____ Date of Birth: _____
Month / Day / Year

How many years/seasons have you played with Team Canada Volleyball: _____

How many years/seasons have you played University Volleyball: _____

How many years/seasons have you played Volleyball in a professional league: _____

ANKLE INJURIES:

Have you ever had an ankle injury?

YES NO

If "yes" please list:

Inversion sprain(R/L)_____

Fracture fibula(R/L)_____

Eversion sprain(R/L)_____

Fracture tibia(R/L)_____

Lateral Malleolar Fracture (R/L)_____

Stress fracture_____(specify bone / region)

Medial Malleolar Fracture (R/L)_____

Other_____

(define "other")

*Please ensure you explain any of the above mentioned injuries in space provided below

Date(s) approximate resolved /unresolved Volleyball related Type of injury

SHOULDER INJURIES:

Have you ever had a shoulder injury?

YES NO

If "yes" please list:

Dislocation(R/L)_____

Sub deltoid bursitis(R/L)_____

Subluxation(R/L)_____

Long head of bicep tendinopathy(R/L)_____

Rotator cuff tendinopathy(R/L)_____

Acromioclavicular separation(R/L)_____

Other_____

(define "other")

*Please ensure you explain any of the above mentioned injuries in space provided below

Date(s) approximate resolved /unresolved Volleyball related Type of injury

BACK AND NECK INJURIES: (cervical,mid back,lowback)

Have you had any back or neck injuries? **YES NO**

If "yes" please list:

- Disc herniation (level)_____ Sacroiliac sprain (R/L)_____
- Muscle strain (which one)_____ Facet joint irritation (level)(R/L)_____
- Rib Subluxation(level)(R/L)_____ Other _____(define "other")

*Please ensure you explain any of the above mentioned injuries in space provided below

Date(s) approximate resolved/unresolved Volleyball related Type of injury

THIGH OR GROIN INJURIES:

Have you ever had a hip or groin injury **YES NO**

If "yes" please list:

- Adductor strain(R/L)_____ Hamstring strain(R/L)_____
- Hip Flexor strain(R/L)_____ Osteitis pubis _____
- Quadricep strain(R/L)_____ Trochanteric bursitis(R/L)_____
- Other _____(define "other")

*Please ensure you explain any of the above mentioned injuries in space provided below

Date(s) approximate resolved/unresolved Volleyball related Type of injury

KNEE INJURIES:

Have you ever had a knee injury? **YES NO**

If "yes" please list:

- Medial collateral ligament(R/L)_____ PCL(R/L)_____
- Lateral collateral ligament(R/L)_____ ACL(R/L)_____
- Medial meniscal tear (R/L)_____ Patellofemoral pain syndrome(R/L)_____
- Lateral meniscal tear(R/L)_____ Patellar tendinopathy/jumper knee(R/L)_____
- Iliotibial band friction syndrome(R/L)_____
- Other _____(define "other")

*Please ensure you explain any of the above mentioned injuries in space provided below

Date(s) approximate resolved/unresolved Volleyball related Type of injury

All other injuries, please check any of the areas that you **have injured in the past and explain that injury below**

Hand/fingers ___ (*fractures?*) Elbow ___ Thigh ___
Wrist ___ Arm ___ Shin / Calf ___ Head ___
Forearm ___ Chest ___ Ankle ___ Foot ___
Concussion ___
Other ___ (define "other")

*Please ensure you explain any of the above mentioned injury in space provided below

Year of injury Type of injury Side (right/left/both) resolved/unresolved
