

MEDICAL HISTORY FORM

(COMPLETION OF THIS SIDE OF THE FORM IS OPTIONAL)

Name: _____ Date: _____

Address: _____ Birthdate: _____

Daytime Phone: _____ Evening: _____ Cell: _____

WHO TO CONTACT IN CASE OF AN EMERGENCY?

Name: _____ Relationship _____

Daytime Phone: _____ Evening: _____ Cell: _____

Physician's Name: _____

Daytime Phone: _____ Evening: _____

Hospital of Choice: _____

PLEASE COMPLETE THE FOLLOWING:

If the answer to any of the following is or was yes, please describe the problem and its implications for proper first aid treatment on a separate piece of paper.

Have you had(or do you presently have) any of the following?	Circle One	
Head injury(concussion or skull fracture)	yes	no
Fainting spells	yes	no
Convulsions/epilepsy	yes	no
Neck or back injury	yes	no
Asthma	yes	no
High Blood pressure	yes	no
Kidney problems	yes	no
Hernia	yes	no
Diabetes	yes	no
Heart murmur	yes	no
Allergies	yes	no

Please specify: _____

Injuries to:

Shoulder _____ yes _____ no _____

Knee _____ yes _____ no _____

Ankle _____ yes _____ no _____

Fingers _____ yes _____ no _____

Arm _____ yes _____ no _____

Other: _____

Impaired vision _____ yes _____ no _____

Impaired hearing _____ yes _____ no _____

Other: _____

Have you had a recent tetanus booster? _____ If so, when? _____

Are you currently taking any medications? _____ What? Why? _____

Has the doctor placed any restrictions on your activity? _____ Explain: _____

Signed: _____ Date: _____

Signed: _____ Date: _____