

# MEDICAL HISTORY FORM

Athlete Name: \_\_\_\_\_ Date: \_\_\_\_\_

Are you presently working?  Yes  No

Date of injury/onset: \_\_\_\_\_

Date of next physician's visit: \_\_\_\_\_

Have you ever had these symptoms before?  Yes  No

Check which apply to your symptoms:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Work related injury           | <input type="checkbox"/> Motor vehicle accident         | <input type="checkbox"/> Cause unknown |
| <input type="checkbox"/> Recurrence of previous injury | <input type="checkbox"/> Injury related to lifting      | <input type="checkbox"/> Other: _____  |
| <input type="checkbox"/> Injury related to falling     | <input type="checkbox"/> Athletic/recreational activity |  |

Have you had a related surgery?  Yes  No

Do you have, or have you had any of the following?

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|--|---|
| <input type="checkbox"/> Diabetes                      | <input type="checkbox"/> Allergies to Aspirin             |
| <input type="checkbox"/> Chest Pain/Angina             | <input type="checkbox"/> Allergies to Heat                |
| <input type="checkbox"/> High Blood Pressure           | <input type="checkbox"/> Allergies/Poor tolerance to cold |
| <input type="checkbox"/> Heart Disease                 | <input type="checkbox"/> Other Allergies                  |
| <input type="checkbox"/> Heart attack                  | <input type="checkbox"/> Hernia                           |
| <input type="checkbox"/> Heart Palpitations            | <input type="checkbox"/> Seizures                         |
| <input type="checkbox"/> Pacemaker                     | <input type="checkbox"/> Metal Implants                   |
| <input type="checkbox"/> Headaches                     | <input type="checkbox"/> Dizziness/Fainting               |
| <input type="checkbox"/> Kidney Problems               | <input type="checkbox"/> Recent Fractures                 |
| <input type="checkbox"/> Are you pregnant?             | <input type="checkbox"/> Surgeries                        |
| <input type="checkbox"/> Cancer                        | <input type="checkbox"/> Skin Abnormalities               |
| <input type="checkbox"/> Osteoporosis                  | <input type="checkbox"/> Sexual Dysfunction               |
| <input type="checkbox"/> Bowel/Bladder abnormalities   | <input type="checkbox"/> Nausea/Vomiting                  |
| <input type="checkbox"/> Urine Leakage                 | <input type="checkbox"/> Ringing in your ears             |
| <input type="checkbox"/> Asthma/Breathing Difficulties | <input type="checkbox"/> Rheumatoid Arthritis             |
| <input type="checkbox"/> Liver/Gallbladder Problems    | <input type="checkbox"/> Special Diet Guidelines          |
| <input type="checkbox"/> Smoking                       | <input type="checkbox"/> Hypoglycemia                     |
| <input type="checkbox"/> Stroke/CVA                    | <input type="checkbox"/> Other: _____                     |

If yes on any of the above, please briefly explain and give approximated date:

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Is there any other information regarding your past medical history that we should know about?

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Are you presently taking any medication?  Yes  No

If yes, please list what medications and for what condition:

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