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:

☐ Work related injury
☐ Recurrence of previous injury
☐ Injury related to falling
☐ Motor vehicle accident
☐ Injury related to lifting
☐ Athletic/recreational activity
☐ Cause unknown
☐ Other:_____

Have you had a related surgery? ☐ Yes ☐ No

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

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