# Medical History Form

**Name:** _____ Date: _____

Address: _____ Birth Date: _____

_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

**Emergency Contact:**

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Physician's Name: _____ Phone: _____

Hospital of Choice: _____

**Indicate if you have had (or presently have) any of the following:**
*If the answer to any of the following questions is yes, please describe the problem and its implications for proper first aid treatment on a separate piece of paper.*

Fainting spells: _____
Convulsions/epilepsy: _____
Neck or back injury: _____
Asthma: _____
High blood pressure: _____
Kidney problems: _____
Hernia: _____
Diabetes: _____
Heart murmur: _____

Impaired vision: _____
Impaired hearing: _____
Head injury (concussion/fracture): _____
Shoulder injury: _____
Knee injury: _____
Ankle injury: _____
Finger injury: _____
Arm injury: _____

Allergies: _____

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

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

_____

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

_____