ATHLETE MEDICAL HISTORY QUESTIONNAIRE

Name: ________________________________ Date of Birth: __________________ Age: ______

Address: ______________________________ City: ______________ State: _____ Zip: _________

Emergency Contact: ______________________________ Day Phone: ____________________

Relationship: ______________________________________ Evening Phone: ________________

Personal Physician: ____

Address: ______________________________ City: ______________ State: _____ Zip: _________

Medical History
Please list any medications taken on a regular basis (prescription & non-prescription):

Medication Dose Frequency Reason

____

____

____

Allergies
Are you allergic to any medications? o Yes o No

If yes, please explain.
Allergic to: Reaction:

____

____

Past and Current Medical History
Please list any current illnesses, recent injuries, recent surgeries, or past medical problems or surgery of note:

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

Heart Disease	o Yes	o No	Asthma	o Yes	o No
Heart Attack	o Yes	o No	Wheezing	o Yes	o No
Heart Surgery	o Yes	o No	Diabetes	o Yes	o No
Heart Murmur	o Yes	o No	Epilepsy	o Yes	o No
Hypertension	o Yes	o No	Anemia	o Yes	o No
Thyroid Problems	o Yes	o No	Stress Fracture	o Yes	o No

If female, any chance you could be pregnant? o Yes o No

Any special medical needs or information the coach should be aware of?