MEDICAL HISTORY FORM PLAYER

(COMPLETION OF THIS SIDE OF THE FORM IS OPTIONAL)

Name _____ Date: _____

Address: _____ DOB: _____

_____

Daytime Phone: _____ Evening Phone: _____

WHO TO CONTACT IN CASE OF AN EMERGENCY?

Name: _____ Relationship: _____

Daytime Phone: _____ Evening Phone: _____

Physician's Name: _____

Daytime Phone: _____ Evening Phone: _____

Hospital of Choice: _____

PLEASE COMPLETE THE FOLLOWING:

If the answer to any of the following questions 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)	Yes	No	Kidney problems	Yes	No
Fainting spells	Yes	No	Hernia	Yes	No
Convulsions/epilepsy	Yes	No	Diabetes	Yes	No
Neck or back injury	Yes	No	Heart murmur	Yes	No
Asthma	Yes	No	Allergies	Yes	No
High blood pressure	Yes	No			

Please specify: _____

Injuries to:

Shoulder	Yes	No	Fingers	Yes	No
Knee	Yes	No	Arm	Yes	No
Ankle	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: _____

_____