Medical history form

Personal details

First name:_____ Last name:_____

Address:_____ P/code_____

Tel: h_____ w_____ mobile_____

Email: _____

Date of birth:____/____/____ Height: _____ cm Sex: female or male

Emergency contact

First name:_____ Last name:_____

Address:_____ P/code_____

Tel: h_____ w_____ mobile_____

Relationship: _____

Health care details

Doctor's name:_____ Tel:_____

Address: _____

Dentist's name:_____ Tel:_____

Address: _____

Medicare number:_____

Health care card: yes / no Number: _____

Private health insurance: yes / no

Name of Fund:_____ Member Number: _____

Blood group:_____ Do you object to blood transfusions? yes / no (please circle)

Medical details / history

Do you require a medical clearance from your doctor? yes / no

If yes, reason: _____

_____

Do you have any food allergies? yes / no

If yes, please list: _____

_____

Any current medical problems?	no	yes
Hand any recent injury requiring medical attention?	no	yes
Are you currently taking any medication?	no	yes
Had any severe head or neck injuries?	no	yes
Had any major surgical operations?	no	yes
Have any chronic illness (epilepsy, diabetes, heart disease)?	no	yes
Do you have any allergies to prescription and/or non –prescription medications?	no	yes

Date of last Tetanus immunisation: _____

If "yes" to any answers above, please explain: _____

_____

Please list any medical conditions that you have (for example, asthma, diabetes, epilepsy):

_____

_____

Please list any regular medications you require (include dosage):

_____

_____

Sports injury details

Please list any current or recurring injuries: _____

_____

_____

Do you suffer from recurring pain in any joint when playing sport? yes / no (please circle)
If yes, please provide details: _____

_____

_____

Have you been treated for head, neck or spinal injury? yes / no (please circle)
If yes, please provide details: _____

_____

_____

If yes, does this condition affect your performance? yes / no (please circle)

If yes, please provide details: _____

_____

_____

Do you wear protective equipment? (eg. mouthguard, head gear) yes / no (please circle)

If yes, please provide details: _____

_____

_____

Do you require specific taping/padding for a previous injury? yes / no (please circle)

If yes, please provide details: _____

_____