Medical History Form

Players First Name:__________________ Middle:________________ Last :____________________
Primary Physician:____________________________________ Phone Number:(_____) ___________
Address ____
Current Medications:____
Hospitalization:____
Operation:____
Please answer the following Yes (Y) or No (N):
Accidents:___________ Explain:____
Allergies: ___________ Explain:____
Asthma: ___________ Explain:____
Chicken Pox:_________ Explain:____
Convulsions:_________ Explain:____
Ear Infections:________ Explain:____
Headaches:__________ Explain:____
Heart Disease:________ Explain:____
Learning Disability:___________ Explain:____
Meningitis:_________ Explain:____
Sickle Cell Disease:___________ Explain:____
Other:________________ Explain:____

Required Medications: _______________ Explain: ____
Hgt: ________ Wt:__________ Blood Type (Optional): ___________

Any problems in the following areas: Yes (Y), No (N)

Skin:______ Explain:____
Eyes:______ Explain:____
Ears:______ Explain: ____
Nose: _____ Explain: ____
Mouth:______ Explain:____
Thyroid:______ Explain: ____
Lungs: _______ Explain: ____
Lymphadenopathy:_______Explain:____
Heart: _______ Explain: ____
Abdomen: ____Explain: ____
Genitalia: _____Explain: ____
Back: _______ Explain: ____
Neurological: ___Explain: ____
Developmental: _______ Explain: ____

Has your son or daughter ever received care for any physical or emotional condition? Yes No
If yes, Doctor/Counselor ____________________________ Phone #:________________________

Is your son or daughter taking any medication for any condition (Circle) Yes NO
If yes, indicate type:__________________________frequency:________________________________

Signature of Primary Physician: ____