Example Medical History Form

Personal details

First name:_____ Last name:_____

Address:_____

Tel: h_____ w_____ mobile_____

Gender: M F (please circle) Date of birth: _____

Emergency contact

First name:_____ Last name:_____

Address:_____

Tel: h_____ w_____ mobile_____

Relationship: _____

Health care details

Doctor's name: _____ Tel:_____

Dentist's name: _____ Tel:_____

Medicare number:_____

Medical details

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

Have you received a medical clearance from your doctor? yes / no (please circle)

Do you have any allergies? yes / no (please circle)

If yes, please list:_____

_____

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:

Do you wear protective equipment? (for example, 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:

Have you ever had a head, neck or spinal injury? yes / no (please circle)

If yes, please provide details:

To the best of my knowledge, all information contained on this form is correct
(if under 18 please have a parent or guardian sign)

Signature:

Date:

Note: *Users of this form are advised that medical information should be treated confidentially. In some states, additional legislation affects the management of health records. See /www.austlii.edu.au for further information.*