ATHLETE MEDICAL HISTORY QUESTIONNAIRE		
Name:	**DOB:**	**AGE:**
Address:		
City:	**State:**	**Zip:**
Home Phone:	**Cell Phone:**	
Personal Physician:		

EMERGENCY CONTACT INFORMATION		
Name:	**Relationship:**	
Address:		
City:	**State:**	**Zip:**
Home Phone:	**Cell Phone:**	

MEDICAL HISTORY			
Please list any medications taken on a regular basis (prescription and nonprescription):			
MEDICATION	**DOSE**	**FREQUENCY**	**REASON**

ALLERGIES	
Are you allergic to any medications? ____NO ____YES	
If Yes, please explain:	
ALLERGIC TO:	**REACTION:**

PAST AND CURRENT MEDICAL HISTORY					
Please list any current illness, recent injuries, recent surgeries, or past medical problems or surgery of note:					
Do you have or have you had, any of the following?					
Heart Disease	○ Yes	○ No	Asthma	○ Yes	○ No
Heart Attack	○ Yes	○ No	Wheezing	○ Yes	○ No
Heart Surgery	○ Yes	○ No	Diabetes	○ Yes	○ No
Heart Murmur	○ Yes	○ No	Epilepsy	○ Yes	○ No
Hypertension	○ Yes	○ No	Anemia	○ Yes	○ No
Thyroid Issue	○ Yes	○ No	Stress Fracture	○ Yes	○ No

If female, any chance you could be pregnant? ____NO ____YES

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