Medical History Form

Personal Details

First Name: _____ **Last Name:** _____
Address:
Tel: h) _____ **w)** _____ **mob)** _____
Gender: M F (please circle) **Date of Birth:** _____

Emergency contact

First Name: _____ **Last Name:** _____
Address:
Tel: h) _____ **w)** _____ **mob)** _____
Relationship: _____

Health care details

Doctor's name: _____ **Tel:** _____
Dentist name: _____ **Tel:** _____
Medicare Number: _____

Medical details

Blood Group: _____ **Do you object to transfusions?** **yes no (please circle)**
Have you received a medial 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 equirpment? (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:

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: _____