ATHLETE MEDICAL HISTORY

Name: ______________________________________

Age:__________Date of Birth: ____________________

Address: ____________________________________

City, State, Zip: _______________________________

Phone: ☐ Home ☐ Cell ___________________________

USAT#:______________________________________

PHYSICIAN:		***EMERGENCY CONTACT:***	
NAME:		NAME:	
ADDRESS:		RELATIONSHIP:	
CITY/STATE/ZIP:		DAY PHONE:	
PHONE:		EVENING PHONE:	

MEDICATIONS: Please list any medications taken on a regular basis (prescription and non-prescription):

MEDICATION	DOSE:	FREQUENCY:	REASON:

ALLERGIES: Are you allergic to any medication? ☐ Yes ☐ No If Yes, Please Explain:

ALLERGIC TO:	REACTION:

PAST & CURRENT MEDICAL HISTORY:

Please list any current illnesses, recent injuries, recent surgeries, or past medical problems or surgery of note:

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Do you have, or have you had, any of the following:

☐ Heart Disease	☐ Heart Attack	☐ Heart Surgery	☐ Heart Murmur
☐ Heart Hypertension	☐ Thyroid Problems	☐ Wheezing	☐ Diabetes
☐ Epilepsy	☐ Anemia	☐ Stress Fracture	

If female, any chance you could be pregnant? ☐ Yes ☐ No

On the back side of this form, please explain any "Yes" answers from above and any medical needs or information the coach should be aware of.