

# 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:

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Do you suffer from recurring pain in any joint when playing sport? yes / no (please circle)

If yes, please provide details:

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Do you wear protective equipment? (for example, mouthguard, head gear)      yes / no  
(please circle)

If yes, please provide details:

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Do you require specific taping/padding for a previous injury? yes / no (please circle)

If yes, please provide details:

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

If yes, please provide details:

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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](http://www.austlii.edu.au) for further information.