MEDICAL HISTORY FORM

PERSONAL DETAILS

First name: .... **Last name:** ....

Address: ....

Suburb .... **State** .... **Postcode** ....

Tel: home .... work .... mobile ....

e-mail .... **Date of birth:** .... **Gender**: M F (please circle)

EMERGENCY CONTACT

First name: .... **Last name:** ....

Address: ....

Suburb .... **State** .... **Postcode** ....

Tel: home .... work .... 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? (e.g. 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.*