Overview of Your Medical History

Name: _____ D.O.B._____/_____/_____

Height: _____ Weight: _____Lbs

Dominate Hand: ☐ R ☐ L

Legal Matter: ☐ Y ☐ N

Occupation: _____

Hobbies: _____

_____

Recreation: _____

_____

Sports: _____

_____

Position Played: _____

_____

Past Surgical History:

Operation Date M/ YR

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Anesthetic complications? ☐ Y ☐ N

Describe: _____

_____

Bleeding complications? ☐ Y ☐ N

Transfusions? ☐ Y ☐ N

Tobacco: _____ Packs Per Day

Alcohol: _____ Drinks Per Day

Have you ever used illegal drugs? ☐ Y ☐ N

When: _____ Type: _____

Frequency: _____

Medications:

Name Dose Frequency

_____

_____

_____

_____

_____

_____

_____

_____

Past Medical History: Date M/ YR

Illnesses: _____

_____

_____

_____

_____

Injuries: _____

_____

_____

_____

_____

_____

_____

Have you ever taken any of the following?

Prednisone: ☐Y ☐ N

Anabolic Steroids: ☐ Y ☐ N

Have you ever been addicted to the following?

Alcohol: ☐ Y ☐ N

Drugs: ☐ Y ☐ N

Are you allergic to Latex ☐ Y ☐ N

Allergies to Medications:

_____

_____

_____

_____

Please check if you ever had any of the following:

(Please circle)

☐ AIDS	☐ Hepatitis A B C
☐ Alcoholism	☐ HIV Positive
☐ Anemia	☐ Kidney Disease
☐ Arthritis	☐ Liver Disease
☐ Asthma	☐ Lung Disease
☐ Bleeding Disorders	☐ Pacemaker
☐ Chemical Dependency	☐ Blood Clots
☐ Diabetes	☐ High Blood Pressure
☐ Emphysema	☐ Low Blood Pressure
☐ Gastrointestinal Dz	☐ Phlebitis
☐ Genitourinary Dz	☐ Recurrent Infections
☐ Heart Disease	☐ Syphilis

Today's Date / /

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