Sports Physical Medical History Form

Personal Information

Full Name

Date of Birth

Address

Phone Number

Emergency Contact

Name

Phone Number

Relationship

Medical History

Have you ever had (check all that apply):

- [ ] Asthma
- [ ] Diabetes
- [ ] Seizures
- [ ] Heart Problems
- [ ] Other

If yes to any above, explain:

Allergies

List any allergies:

Current Medications

List any medications you are currently taking:

Past Injuries or Surgeries

List any past injuries or surgeries:

Additional Information

Other important information: