

# MISSIONSPORTS FOUNDATION

## Confidential Medical History Form

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Personal History:** Please answer all questions. Explain any 'YES' answers in the space provided below.

HAVE YOU EVER HAD, OR DO YOU HAVE, ANY OF THE FOLLOWING?

(check if "yes" and describe below)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Skin Conditions           | <input type="checkbox"/> Shortness of Breath     | <input type="checkbox"/> Stomach/duodenal ulcer |
| <input type="checkbox"/> Eye Trouble               | <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Gall Bladder Problems  |
| <input type="checkbox"/> Ear Trouble               | <input type="checkbox"/> Heart Trouble           | <input type="checkbox"/> Jaundice               |
| <input type="checkbox"/> Head Injury               | <input type="checkbox"/> Abnormal Blood Pressure | <input type="checkbox"/> Hepatitis              |
| <input type="checkbox"/> Recurrent headache        | <input type="checkbox"/> Knee problems           | <input type="checkbox"/> Intestinal Troubles    |
| <input type="checkbox"/> Epilepsy                  | <input type="checkbox"/> Rheumatism/Arthritis    | <input type="checkbox"/> Recurrent Diarrhea     |
| <input type="checkbox"/> Fainting Spells/dizziness | <input type="checkbox"/> Back Problems           | <input type="checkbox"/> Diabetes               |
| <input type="checkbox"/> Mental Disorders          | <input type="checkbox"/> Dislocation of Joints   | <input type="checkbox"/> Kidney Disease         |
| <input type="checkbox"/> Weakness                  | <input type="checkbox"/> Broken Bones            | <input type="checkbox"/> Anemia                 |
| <input type="checkbox"/> Paralysis                 | <input type="checkbox"/> Eating Disorders        | <input type="checkbox"/> Venereal Disease       |
| <input type="checkbox"/> Insomnia                  | <input type="checkbox"/> Anorexia Nervosa        | <input type="checkbox"/> Tumor; Cancer          |
| <input type="checkbox"/> Allergies                 | <input type="checkbox"/> Bulimia                 | <b>Females Only</b>                             |
| <input type="checkbox"/> Penicillin                | <input type="checkbox"/> Past Surgery            | <input type="checkbox"/> Irregular Periods      |
| <input type="checkbox"/> Sulfonamides              | <input type="checkbox"/> Appendectomy            | <input type="checkbox"/> Severe Cramps          |
| <input type="checkbox"/> Serum                     | <input type="checkbox"/> Hernia Repair           | <input type="checkbox"/> Excessive Flow         |
| <input type="checkbox"/> Other – (specify)         | <input type="checkbox"/> Tonsillectomy           | <input type="checkbox"/> Are you pregnant?      |

Explain \_\_\_\_\_

Are you now, or have you recently been, under a doctor's care for any conditions? If yes, explain.

Do you presently take any medication on a regular basis? If yes, explain.

Are you allergic to any of the following? If yes, please describe your reaction and how you treat it.

- Insects  Foods  Medication(ex: penicillin, aspirin, sulfa drugs)  Environmental  Other

Do you have any physical handicaps or health conditions that require special attention? Explain.