
MEDICAL HISTORY FORM
ATHLETE'S SURNAME
ATHLETE'S GIVEN NAME
ADDRESS:
SPORT/EVENT
MALE
FEMALE
DATE OF BIRTH (M
DATE OF LAST TETANUS BOOSTER:
BLOOD GROUP & TYPE:
HEIGHT:
WEIGHT:
PHONE (DAY):
PHONE (DAY):
PHONE (DAY):
LINE PAST HISTORY OR ILLNESS
VE YOU EVER HAD OR DO YOU NOW HAVE:
YES
NO
HEAD INJURY
SEIZURES
NECK/BACK DISORDER
FAINTING SPELLS
PSYCHIATRIC DISORDER
EYE PROBLEMS
GLASSES/CONTACTS
NOSE BLEEDS
DENTAL PROBLEMS
DEAFNESS/EAR PROBLEMS
ASTHMA
BRONCHITIS
CHEST PAINS
HEART PROBLEMS
ULCERS
BOWEL PROBLEMS
URINARY INFECTIONS
KIDNEY PROBLEMS
MENSTRUAL PROBLEMS
EATING DISORDERS
DIABETES
BLOOD TRANSFUSIONS
HEPATITIS
THYROID DISORDER
ALLERGIES
(SPECIFY)
FRACTURES
(SPECIFY)
OPERATIONS
(SPECIFY)
RECENT WITHIN ONE YEAR:
INFECTIOUS DISEASE
HEAD INJURY
MAJOR SURGERY
TRAUMATIC OR OVERUSE INJURY
LIST ANY OTHER HEALTH PROBLEMS/RELEVANT INFORMATION OR EXPLAIN ANY OF THE CONDITIONS MARKED 'YES':
Initial Pain Assessment Tool
Date
Patient's Name
Age
Room
Diagnosis
Physician
Nurse
1. LOCATION: Patient or nurse mark drawing.
Right
Left
LEFT
RIGHT
2. INTENSITY: Patient rates the pain. Scale used
Present pain:
Worst pain gets:
Best pain gets:
Comfort-function goal:
3. IS THIS PAIN CONSTANT?
YES;
NO
IF NOT, HOW OFTEN DOES IT OCCUR?
4. QUALITY: (e.g., ache, deep, sharp, hot, cold, like sensitive skin, sharp, itchy)
5. ONSET, DURATION, VARIATIONS, RHYTHMS:
6. MANNER OF EXPRESSING PAIN:
7. WHAT RELIEVES THE PAIN?