Medical Questionnaire

Name:_____ Date:_____

Date of Birth:_____ Age:_____ Sex: M / F

Height:_____ Weight:_____

Blood Type:_____ Marital Status:_____

PCP:_____ Phone:_____

Emergency Contact:
Name:_____ Phone:_____
Phone:_____

Assignment:_____

General Health: Excellent V. Good Good Fair

Allergies (Drug and Reaction):

_____

_____

Past Medical History: (Circle Positives)

HTN COPD CHF CAD Diabetes CVA

Osteoarthritis Connective Tissue Disorder_____

Murmur Renal Disease:_____ High Cholesterol Thyroid Disease: Hyper / Hypo

Cancer:_____

GERD Ulcers Anemia BPH Asthma

Other:_____

Past Surgical History: (Circle Positives)

Appendectomy Cholecystectomy TURP CABG Cathertization Laporatomy

TAH D&C C-Section Other:_____

Hospitalizations: (Year, Hospital, Reason)

1._____

2._____

3._____

Trauma:
MVC GSW Stabbing Falls Sports

Immunizations: (Date and Type)

Tetnus:_____ **Influenza:_____**
MMR:_____ **Varivax:_____**
Hepatitis A:_____ **Hepatitis B:_____**
Pneumoinia:_____ **Polio:_____**

Family History: (Circle Positives)

CAD CVA Diabetes HTN Cancer

Social History:

Tobacco ETOH: Social Occasional Heavy Drugs:_____
Exercise:_____ Dieting:_____
Caffeine:_____ Children:_____

Female:
Last Menstrual Period:_____
Age on onset:_____ Post-menopausal:_____
Number of Pregnancies:_____ Number of Live Births:_____
Frequent UTIs:_____

Medications:

Name: Dose: Reason: (include herbals, vitamins)
1._____
2._____
3._____
4._____
5._____
6._____
7._____

ROS: (Circle Positives in last month)

Fever Chills Weakness Weight Loss Weight Gain NightSweats Headache Dizzyness
VisionChanges HearingChanges RunnyNose NeckPain Rashes ChestPain Shortness-of-Breath
Nausea Vomiting AbdominalPain Diarrhea MusclePain JointPain JointSwelling
Numbness AbnormalSensations Incontinence IncreasedThirst IncreasedUrination BurningUrination
Urethral Discharge VaginalDischarge VaginalBleeding Insomia BackPain

Base Line Vitals:

Heart Rate:_____ Respiratory Rate:_____ BP:_____

Verified by:_____ Date:_____
Updated:_____ Updated:_____

Note: This information may be shared with healthcare providers in the event of injury or illness during racing/sailing functions/operations: Y N Init:_____

All Information contained in this document is confidential, to be used only in the healthcare of the named individual. Release or access by any others besides physicians or individual named above is forbidden.

Ver 1.5, 4/2016 (Place in envelope, place on person (right thigh pocket) or Clothes bag or backpack.