

ITYFL MEDICAL HISTORY FORM

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Fr ~~\_\_\_\_\_~~

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_

Does your child currently have, or have they ever suffered from any of the following? Please explain all "yes" answers in the space provided to the right. Use the back for additional space if you need it.

- a. Headâches needing treatment      Y N \_\_\_\_\_
- b. Heart      Y N \_\_\_\_\_
- c. Breathing (i.e. Asthma)      Y N \_\_\_\_\_
- d. Abdominal pain      Y N \_\_\_\_\_
- e. Dizzy Spells      Y N \_\_\_\_\_
- f. Black Outs      Y N \_\_\_\_\_
- g. Eyes (except Glasses)      Y N \_\_\_\_\_
- h. Hearing (or ears)      Y N \_\_\_\_\_
- i. Arthritis      Y N \_\_\_\_\_
- j. Joint Pain or Swelling      Y N \_\_\_\_\_
- k. Knees      Y N \_\_\_\_\_
- l. Spine, Back, or Neck      Y N \_\_\_\_\_
- m. Broken Bones      Y N \_\_\_\_\_
- n. Kidneys/Bladder      Y N \_\_\_\_\_
- o. Diabetes      Y N \_\_\_\_\_
- p. High Blood Pressure      Y N \_\_\_\_\_
- q. Operations (or surgery)      Y N \_\_\_\_\_
- r. Drug Allergies      Y N \_\_\_\_\_
- s. Other Allergies      Y N \_\_\_\_\_

Have you ever been knocked unconscious?      Y N \_\_\_\_\_

Are you presently taking any medications?      Y N \_\_\_\_\_

Any special conditions I should be aware of?      Y N \_\_\_\_\_