Arizona State University®
Sun Devil® Hockey Club

ACHA
American Collegiate
Hockey Association

MEDICAL HISTORY FORM

Name ______ Date of Birth ______ Today's date ______

1. List any old injuries and brief description of how they happened

2. Have you had any previous surgery

3. Have you consulted a physician for any reason in the past 3 years? If so, for what?

4. List doctors you have seen within the last 3 years

5. Have you lost weight recently? **Yes** **No** Current Ht. ______ Current Wt. ______

6. What medications are you currently taking?

7. Are you allergic to any medication? **Yes** **No** If so, what?

8. Is there any history of diabetes, heart disease or other familial diseases in your family? **Yes** **No**

9. Have you had any of the following? If so, please check and give detail.

Recent cold	Yes___	No___	Constipation	Yes___	No___
Eye problems	Yes___	No___	Change in bowel habits	Yes___	No___
Sore throat	Yes___	No___	Bloody or tarry stools	Yes___	No___
Earache	Yes___	No___	Rectal bleeding	Yes___	No___
Nose bleeds	Yes___	No___	Hepatitis	Yes___	No___
Headache	Yes___	No___	Yellow jaundice	Yes___	No___
T.B.	Yes___	No___	Alcoholism	Yes___	No___
Valley Fever	Yes___	No___	Kidney or bladder problems	Yes___	No___
Asthma	Yes___	No___	Kidney or bladder infections	Yes___	No___
Emphysema	Yes___	No___	Kidney stones	Yes___	No___
Chronic cough	Yes___	No___	Difficulty in urinating	Yes___	No___
Heart disease	Yes___	No___	Incontinence (unable	Yes___	No___
Heart attack	Yes___	No___	to control urination or stool)	Yes___	No___
Chest pain	Yes___	No___	Bloody urine	Yes___	No___
Shortness of breath	Yes___	No___	Faintness	Yes___	No___
Ankle swelling	Yes___	No___	Numbness	Yes___	No___
High blood pressure	Yes___	No___	Convulsions	Yes___	No___
Ulcers	Yes___	No___	Paralysis	Yes___	No___
IV Drug use	Yes___	No___	Diabetes	Yes___	No___
Indigestion	Yes___	No___	Insulin dependent	Yes___	No___
Heartburn	Yes___	No___			

10. Do you smoke? **Yes** **No** How much?

11. Are you nervous, **Yes** **No** fatigue easily? **Yes** **No**

12. Do you use drugs (Marijuana, LSD, Heroin, Cocaine)? **Yes** **No**