

Medical Medical History Questionnaire

This is your medical history form, to be completed prior to acceptance. All information will be kept confidential. This information will be used for the evaluation of your health and readiness to begin training. The form is extensive; please try to make it as accurate and complete as possible. Please take your time and complete it carefully and thoroughly, and then review it to be certain you have not left anything out. The answers given here as well as other factors, will help us determine if you are cleared as a candidate.

If you have questions or concerns, if you have a significant cardiac or musculoskeletal injury history you may want to have a formal medical clearance exam by your medical provider prior to the course as a medical clearance.

Name/Signature: _____

Date: _____

General Information

Participant:

Address _____

Contact phone numbers _____

Birth date _____

Family Physician and/or Primary Health Care Provider:

Doctor/Other _____ Phone _____

Address _____ City _____

Occupation:

Position _____ Employer _____

Address _____

Phone _____

Present Medical History

Check those questions to which you answer yes (leave the others blank).

- Have you had a heart attack or cardiac bypass surgery/procedure?
- Are you on blood pressure or anticoagulant medications?
- Do you ever have pain in your chest or heart?
- Are you often bothered by a thumping or irregular beat of the heart?
- Has a doctor ever said that you have or have had heart trouble, an abnormal electrocardiogram (ECG or EKG), heart attack or coronary?
- Do you often have difficulty breathing?
- Do you get out of breath long before anyone else?
- Chronic, recurrent or morning cough, or respiratory disease?
- Increased anxiety or depression? Nervous or emotional problems or PTSD?
- Migraine or recurrent headaches?

- Swollen or painful knees or ankles, stiff or painful joints or arthritis?
- Back problems?
- Significant vision or hearing problems?
- Injuries to back, arms, legs or joints?
- Any problem that prevents participation in athletics, combatives, hot or cold weather physical performance in an austere setting?
- Diabetes or abnormal blood-sugar tests
- Dizziness or fainting spells
- Epilepsy or seizures

Comments _____

Prescription medications/supplements: _____

List any drug allergies: _____

Comments _____
