THE WARRIOR CLINIC

Athlete Medical Form

Name	
Date of Birth	
Gender	
Medical Problems	❑ Diabetes (Type 1 or Type 2) ❑ Cardiovascular disease (Hypertension, Angina, Heart attack) ❑ Neurologic (Seizure, Stroke, TIA) ❑ Asthma/ Difficulty Breathing ❑ ❑ ❑
Medications and reason (Prescription and OTC)	❑ ❑ ❑
Prior Medical Problems Or Hospitalizations	❑ ❑
Prior Surgeries	❑
Allergies	❑
Previous Injuries/ Joint Pain	❑ ❑
Other	❑

Biomarker/ Measurement	Date	Date	Date	Date
Weight				
Height				
Heart Rate				
Blood Pressure				
Body Fat %				
Abdominal Girth				
HgbA1C				
TG				
HDL				