



INTRAMURAL-RECREATIONAL SPORTS

UNIVERSITY OF VIRGINIA

Health History Form

Name: _____ Date: _____ Age: _____ Gender: M or F

Physician's Name: _____

Physician's Phone: _____

Person to Contact in Case of an Emergency: _____

Relationship: _____ Phone: _____

Are you taking any medications or drugs? If so, please list medication, dose or reason.

Describe any physical activity you do somewhat regularly. Do you now, or have you had in the past:

Table with 3 columns: Question, YES, NO. Contains 15 health-related questions for a physical activity form.