

SPORTS MEDICINE CENTER MEDICAL HISTORY FORM

TODAY'S DATE ___ / ___ / ___ NAME: _____
AGE: _____ SEX: M F HEIGHT _____ WEIGHT _____
ARE YOU RIGHT OR LEFT HANDED _____
PRIMARY CARE PHYSICIAN: _____ PHONE: _____
REFERRING PHYSICIAN: _____ PHONE: _____

CURRENT MEDICAL:

LIST OF MEDICATIONS YOU ARE CURRENTLY TAKING:

LIST MEDICATION ALLERGIES *IF YOU DO NOT HAVE ANY PLEASE CIRCLE NONE.

OR: NONE (NO KNOWN ALLERGIES OR SENSITIVITIES)

CURRENT MEDICAL COMPLAINT: (CONDITION THAT YOU ARE BEING SEEN FOR)

PAST MEDICAL HISTORY: (LIST MAJOR SURGERIES OR MEDICAL PROBLEMS)

SURGERY OR PROBLEM: _____ DATE: ___ / ___ / ___

SURGERY OR PROBLEM: _____ DATE: ___ / ___ / ___

SURGERY OR PROBLEM: _____ DATE: ___ / ___ / ___

FAMILY HISTORY: (CHECK THE MEDICAL PROBLEMS THAT YOUR MOTHER, FATHER, SIBLINGS, OR CHILDREN HAVE OR HAD)

CANCER	TUBERCULOSIS	DIABETES	HEART TROUBLE	STROKE
EPILEPSY	HIGH BLOOD PRESSURE	ARTHRITIS	EASY BLEEDING	
OTHER/PLEASE SPECIFY: _____				

DO YOU:

YES NO EXERCISE DAILY
YES NO PARTICIPATE IN SPORTS/WHICH SPORTS _____
YES NO SMOKE TOBACCO/HOW MUCH PER DAY _____ HOW LONG _____
YES NO CONSUME ALCOHOL/HOW MUCH _____ HOW OFTEN _____

OCCUPATIONAL CONCERNS: (CHECK IF YOU WORK EXPOSES YOU TO THE FOLLOWING)

STRESS HAZARDOUS SUBSTANCES HEAVY LIFTING OTHER

YOUR OCCUPATION: _____

**MEDICAL HISTORY FORM
(CONTINUED)**

SYMPTOMS:(CHECK SYMPTOMS YOU ARE CURRENTLY HAVING OR HAVE HAD IN THE LAST YEAR)

GENERAL

ANXIETY
CHILLS
DEPRESSION
DIZZINESS
FAINTING
FEVER
FORGETFULNESS
HEADACHE
LOSS OF SLEEP
NERVOUSNESS
NUMBNESS
SWEATS

GASTROINTESTINAL

ABDOMINAL PAIN
BLOODY OR TARRY STOOLS
COLITIS/DIVERTICULITIS
CONSTIPATION
DIARRHEA
FREQUENT INDIGESTION/GERD
GALL BLADDER PROBLEMS
HEMORRHOIDS
NAUSEA
RECTAL BLEEDING
STOMACH PAIN
ULCER DISEASE
VOMITING

EARS, EYES, NOSE, THROAT

BLEEDING GUMS
BLURRED VISION
DIFFICULTY HEARING
DIFFICULTY SEEING-GLASSES/CONTACTS
EARACHE
EAR DISCHARGE
FREQUENT COUGHING
HAY FEVER/ALLERGIES
NOSE BLEEDS
RINGING IN EARS
SINUS PROBLEMS
TOOTH OR GUM PROBLEMS
DENTURES
HEARING AIDS

MUSCLE/JOINT/BONE

ARTHRITIS
BURSITIS
CLUBBING
EFFUSIONS/HEMARTHROSIS
FREQUENT DISLOCATION
INFLAMATION PROBLEMS
JOINT STIFFNESS
LOSS OF MOTION
PAIN
RECURRENT BACK PAIN
SWELLING
TENDERNESS

CARDIOVASCULAR

CHEST PAIN/ANGINA
HEART ATTACK
HEART MURMUR
HIGH BLOOD PRESSURE
IRREGULAR HEART BEAT
LOW BLOOD PRESSURE
POOR CIRCULATION
RAPID HEART BEAT
STROKE
VARICOSE VEINS
DVT/PULMINARY EMBOLISM
BLOOD CLOTS

SKIN

CHANGE IN MOLES
EASY BLEEDING
EASY BRUISING
HIVES
ITCHING
LESIONS
OPEN SORES
RASH
ULCERS
PSORIASIS
ECZEMA

RESPIRATORY

ASTHMA/WHEEZING
BRONCHITIS
PNEUMONIA
SHORTNESS OF BREATH
SLEEP APNEA-DO YOU REQUIRE CPAP/BYPAP MACHINE YES/NO

URINARY

DIFFICULT URINATION
FREQUENT URINATION
URINARY TRACT INFECTION
KIDNEY STONES OR PROBLEMS

ENDOCRINE

DIABETES
THYROID PROBLEMS

OTHER _____.

CONDITIONS: (CHECK CONDITIONS THAT YOU HAVE OR HAVE HAD IN THE PAST)

ALCOHOLISM
BLEEDING DISORDERS
CANCER
CATARACTS
CHEMICAL DEPENDENCY
DRUG ABUSE/PAST USE
EMPHYSEMA
GLAUCOMA
FIBROMYALGIA
RESTLESS LEG SYNDROME

GOUT
HEPATITIS
HERNIA
HIV INFECTION
MULTIPLE SCLEROSIS
PACEMAKER
PSYCHIATRIC CARE
SUICIDE IDEATION
SUICIDE ATTEMPT

SEIZURES
THYROID PROBLEMS

OTHER _____.

_____.

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOT HOLD MY PHYSICIAN OR ANY MEMBER OF HIS/HER STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I HAVE MADE IN THE COMPLETION OF THIS FORM:

SIGNATURE: _____.
REVIEWED BY: _____.

DATE: _____.
DATE: _____.