



Date _____

Women's Sports Medicine Center

Confidential Medical History

Name _____ Age _____ Birthdate _____

Home # _____ Work # _____

Occupation _____ Referred by _____

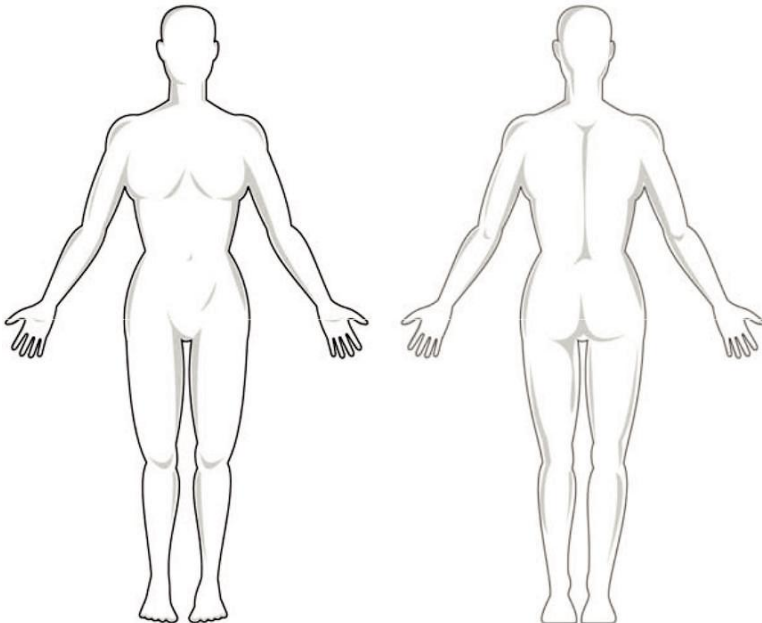
Right Handed (select) Left Handed (select)

Chief Complaint _____

Date of injury or onset of symptoms _____

Describe the injury or problem _____

Where is your pain? Please mark the drawing.



Rate Your Pain:

0 = No pain 10 = Extreme pain

	0	1	2	3	4	5	6	7	8	9	10
1. Right now	0	0	0	0	0	0	0	0	0	0	0
2. At best	0	0	0	0	0	0	0	0	0	0	0
3. At worst	0	0	0	0	0	0	0	0	0	0	0

4. What makes it better? _____

5. What makes it worse? _____

Have you had any of the following tests or treatments for this problem? (please check)

- Tests** **Date(s) of your tests**
- X-RAY _____
 - MRI _____
 - CT SCAN _____
 - MYELOGRAM _____
 - BONE SCAN _____

- Treatments** (If so, describe whether they helped.)
- MEDICATIONS _____
 - INJECTIONS _____
 - SURGERY _____
 - PHYSICAL THERAPY _____
 - OTHER TESTS AND TREATMENTS _____

Would you like us to send copies of your notes to your primary care physician? Y N

Primary Care Physician _____
Mailing Address _____
Phone # _____ Fax # _____

Your Medical History

Do you have any medical problems? (Diabetes, high blood pressure, etc) _____

Have you ever been hospitalized? Y N If yes, why? _____

Have you ever had surgery? Y N If yes, why and when? _____

List of medications _____

Are you allergic to any medication? Y N If yes, list. _____

Are you allergic to any contrast dyes? Y N

Are you allergic or sensitive to latex? Y N

Family History

Does anyone in your family have any of the following problems? (please check)

- | | | | |
|--|--|---|---------------------------------------|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Anesthesia complications | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Nerve problems | <input type="checkbox"/> Blood problems (anemia, abnormal bleeding) | <input type="checkbox"/> Hip fracture |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Other: _____ |

Current Symptoms or Problems

Please check Yes or No for any of the following that apply to you:

- | Yes | No | | Yes | No | |
|--------------------------|--------------------------|---|--------------------------|--------------------------|----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Recent weight change | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers |
| <input type="checkbox"/> | <input type="checkbox"/> | Change in bowel habits (also blood in stools) | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis or gallbladder disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Fatigue/weakness | <input type="checkbox"/> | <input type="checkbox"/> | Frequent headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood disorder or blood transfusion | <input type="checkbox"/> | <input type="checkbox"/> | Fainting spells |
| <input type="checkbox"/> | <input type="checkbox"/> | Fever, chills | <input type="checkbox"/> | <input type="checkbox"/> | Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Easy bleeding | <input type="checkbox"/> | <input type="checkbox"/> | Problems with coordination |
| <input type="checkbox"/> | <input type="checkbox"/> | Easy bruising | <input type="checkbox"/> | <input type="checkbox"/> | Depression |
| <input type="checkbox"/> | <input type="checkbox"/> | Skin rash/disease | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Change in urinary habits (including pain, blood in urine, trouble stopping/starting your urine) | <input type="checkbox"/> | <input type="checkbox"/> | Change in appetite or thirst |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney disease or kidney stones | <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath or wheezing |
| <input type="checkbox"/> | <input type="checkbox"/> | Vision problems/eye disease | <input type="checkbox"/> | <input type="checkbox"/> | Frequent cough |
| <input type="checkbox"/> | <input type="checkbox"/> | Eating disorder | <input type="checkbox"/> | <input type="checkbox"/> | Chest pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Nose/throat problem | <input type="checkbox"/> | <input type="checkbox"/> | Heart murmur |
| <input type="checkbox"/> | <input type="checkbox"/> | Hearing problems/ear disease | <input type="checkbox"/> | <input type="checkbox"/> | Irregular heart beat |
| <input type="checkbox"/> | <input type="checkbox"/> | Stomach pain or heartburn | <input type="checkbox"/> | <input type="checkbox"/> | Heart disease |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | Swollen legs or feet |

Social History and Health Habits

Do you smoke cigarettes? Y N ____ packs/day For how long? ____ yrs
Have you smoked in the past? Y N ____ packs/day For how long? ____ yrs Quit date _____
Do you drink alcohol? Y N ____ drinks/wk

Number of Children: 0 1 2 3 4 or more
Marital Status: Married Single Widowed Divorced

How would you describe your level of physical activity over the past six months?
 Inactive - just daily activity
 Light - some walking, gardening, occasional weekend recreational activity
 Moderate - regular (3x per week) moderate exercise and occasional weekend sports
 Vigorous - regular (3-5x per week) vigorous exercise and/or sports activity
 Intense - competitive vigorous sports training

Height _____ feet/inches Weight _____ lb
Do you consider your current weight ideal? Y N If no, list your ideal weight _____
Do you have questions about healthy ways to control your weight? Y N

For Females Only: Gynecological History

Do you think you might be pregnant at this time? Y N
Do you use birth control? Y N If yes, what type? _____
Have you experienced menopause or a hysterectomy? Y N
If yes, what and when? _____
Date of last pap smear _____ Date of last mammogram _____
Age you began your first period _____ When was your most recent menstrual period? _____
How many periods have you had during the last 12 months? (check one)
 10-12 7-9 5-6 1-6 none
Number of Pregnancies: 0 1 2 3 4 or more

Are there any specific questions that you would like to discuss today?

- 1. _____
- 2. _____
- 3. _____

Signed by Patient: _____ ***Date:*** _____

Office only: *Reviewed by:* _____ *Date:* _____