Date_____

Women's Sports Medicine Center

Confidential Medical History

Name _____ Age _____ Birthdate_____

Home # _____ Work # _____

Occupation_____ Referred by_____

○ Right Handed ○ Left Handed

Chief Complaint _____

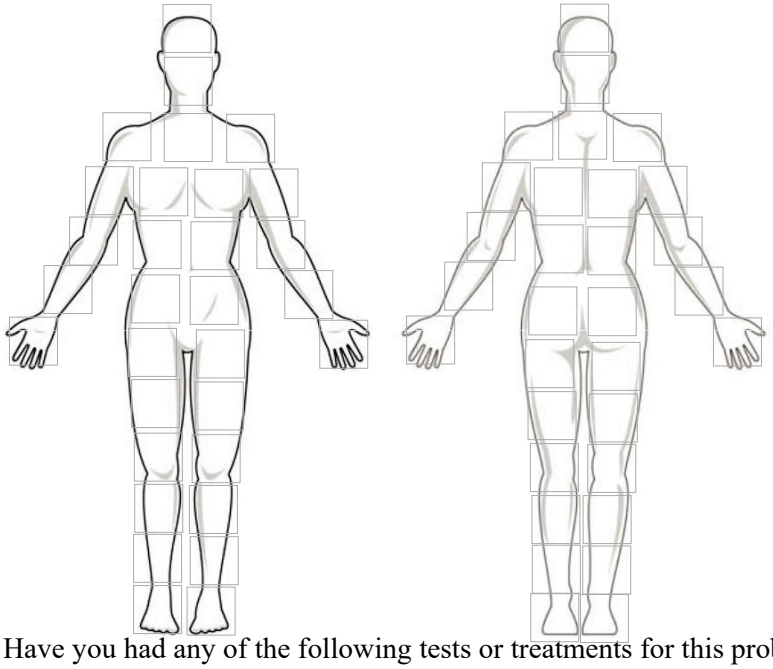
Date of injury or onset of symptoms _____

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	○	○	○	○	○	○	○	○	○	○	○
2. At best	○	○	○	○	○	○	○	○	○	○	○
3. At worst	○	○	○	○	○	○	○	○	○	○	○

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)

☐ Heart disease	☐ High blood pressure	☐ Anesthesia complications	☐ Osteoporosis
☐ Cancer	☐ Nerve problems	☐ Blood problems (anemia, abnormal bleeding)	☐ Hip fracture
☐ Stroke	☐ Diabetes	☐ Osteoarthritis	☐ Other: _____

Current Symptoms or Problems

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

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