



SLU Sports Medicine Medical History Form

Please fill out completely due to this being a part of your permanent medical record.

Name: _____ Date: _____ SS#: _____

Pregnant: Y / N Age: _____ DOB: _____ Right / Left Handed: _____

Date of Accident / Injury: _____

Telephone Numbers:

Home () _____ - _____ Cell () _____ - _____ Work () _____ - _____

Drug Allergies: _____ Height: _____ Weight: _____

Reason for Visit: _____

Please describe the recent events of this current orthopaedic problem. Answer how long it has been a problem, what makes it worse, and what makes it better:

Have you had/taken any of the following? (please circle all that apply)

Physical therapy Other Injections (specify _____)

Injections of cortisone Advil, Motrin, Alleve, ibuprofen, other pain medications (specify _____)

Please list all current medications:

1. _____	4. _____
2. _____	5. _____
3. _____	6. _____

Past Surgeries: Please list in chronological order from oldest to newest and year of surgery.

1. _____	3. _____
2. _____	4. _____

Diagnostic Studies: List any you have had for this condition along with the date and place the study was performed (MRI, CT, X-rays, EMG, etc)

1. _____	3. _____
2. _____	4. _____

Family Medical History: List medical illnesses affecting your immediate family (parents, siblings)

<u>Disease</u>	<u>Family Member</u>	<u>Disease</u>	<u>Family Member</u>
1. _____	_____	3. _____	_____
2. _____	_____	4. _____	_____

Social History: Check and fill in the blanks

Married ____ Single ____ Divorced ____ Live Alone ____ # of Children ____
 Alcohol ____ Occasional ____ Moderate ____ Heavy ____ History of drug abuse ____
 Tobacco ____ Years used ____ Packs/day ____ Recreational drugs ____ Years used ____

General History: Please Check if any apply.

General-Skin-Endo:

- ___ 1 Weight change
- ___ 2 Fever or chills
- ___ 3 Night sweats
- ___ 4 Urinary frequency
- ___ 5 Bleeding
- ___ 6 Lumps of masses
- ___ 7 Dizziness or fainting
- ___ 8 Itching or rash
- ___ 9 Diabetes Mellitus
- ___ 10 Thyroid problems
- ___ 11 Cancer
- ___ 12 Other

Gastrointestinal:

- ___ 1 Dysphagia (swallowing difficulties)
- ___ 2 Nausea & vomiting
- ___ 3 Jaundice
- ___ 4 Hepatitis
- ___ 5 Other

Genitourinary:

- ___ 1 Urinary tract infections
- ___ 2 Incontinence
- ___ 3 Venereal diseases
- ___ 4 Menopause
- ___ 5 Other

Cardiovascular:

- ___ 1 Heart diagnosis / pain
- ___ 2 Hypertension
- ___ 3 Mitral valve prolapse
- ___ 4 Thrombophlebitis
- ___ 5 Other

Neurologic:

- ___ 1 Seizures
- ___ 2 Paralysis
- ___ 3 Numbness
- ___ 4 Weakness
- ___ 5 Other

Musculoskeletal:

- ___ 1 Backache
- ___ 2 Joint pain
- ___ 3 Joint swelling
- ___ 4 Fractures
- ___ 5 Other

Ear-Nose-Throat-Eye:

- ___ 1 Visual changes
- ___ 2 Hearing problems
- ___ 3 Tinnitus
- ___ 4 Dentures
- ___ 5 Bleeding gums
- ___ 6 Hoarseness
- ___ 7 Other

Respiratory-Allergy:

- ___ 1 Cough / sputum
- ___ 2 Rheumatic fever
- ___ 3 Tuberculosis
- ___ 4 Pleurisy / pneumonia
- ___ 5 COPD / Emphysema
- ___ 6 Asthma
- ___ 7 Shortness of breath
- ___ 8 other

Hematologic Disorders:

- ___ 1 Bleeding disorders
- ___ 2 Anemia
- ___ 3 Platelet problems
- ___ 4 Other

Mental Health:

- ___ 1 Depression
- ___ 2 Trouble concentrating
- ___ 3 Anxiety attacks
- ___ 4 Other

Other medical conditions not listed above:

- 1. _____
- 2. _____

Description of current employment / occupation: - _____

Is injury work related? ___ Yes ___ No Current litigation regarding injury: ___ Yes ___ No

Which physician referred you to our office? _____

Name and phone number of primary care physician: _____

Patient's Signature

Date