

## Sports Medicine & Orthopaedics Medical History Form

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Family Physician: \_\_\_\_\_

Complaint: \_\_\_\_\_

Date of injury: \_\_\_\_\_

Have you been treated for this problem prior to coming to the office? **YES NO**

Where? \_\_\_\_\_ when? \_\_\_\_\_

Is your injury or complaint work related? **YES NO**

Are you currently on disability? **YES NO**

Are you currently working? **YES NO**

Describe the work you currently do \_\_\_\_\_

Social History: **MARRIED/SINGLE** Do you use alcohol? **YES NO** Do you smoke? **YES NO**

Use Drugs? **YES NO**

Past Medical History: What previous medical problems have you been treated for?

Insulin Dependent Diabetes

Non-Insulin Dependent

Diabetes

Hypertension

Heart Disease

Liver Disease

Kidney Disease

Thyroid Disease

Cancer: What type? \_\_\_\_\_

Lung Disease

Asthma

Seizures

Osteoarthritis

Rheumatoid Arthritis

Alcoholism

Drug addiction

Past surgical history: What previous surgeries have you had? When? \_\_\_\_\_

What previous Orthopaedic surgeries have you had? When? \_\_\_\_\_

Did you have any complications with the surgery or anesthesia? **YES NO**

Do you have any bleeding disorders? **YES NO** Do you take any blood thinners? **YES NO**

Do you currently have complaints with any of the following?

Fevers

Chills

Weight Loss

Weight Gain

Muscle weakness

Ulcers

Diarrhea

Dizziness

Eyes Ears Nose

Throat complaints

Urinary Tract Infections

Bowel Complaints Chest Pain

High Blood Pressure

Skin Lesions

Difficulty Breathing

Shortness of Breath

Headaches

Do you have any other medical conditions or problems that have not been discussed?

\_\_\_\_\_

