



Sports Medicine Medical History Form

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Patient Name
MR #

Patient Name: Birth Date: Today's Date:

Gender: M / F Height Weight Right or Left Handed? R / L

Referring Doctor: Primary Care Physician (if different):

May we contact your primary care physician about today's visit? Y / N

HISTORY OF CURRENT PROBLEM:

Reason for today's visit:

Approximate date symptoms started: Is this problem due to an injury? Y / N

Please describe what you were doing when the symptoms started:

How do the symptoms limit your activities?

What makes your symptoms worse?

What treatment(s) did you already try for your symptoms? (Please circle all that apply)

Ice Heat Massage Stretching Brace Ace Wrap Medicine (please list names)

Other (please list)

Which treatment(s) helped?

Please rate your current pain on a scale of 1 -10 with 10 being the worst pain:

Have you had similar symptoms before? Y / N If yes, please describe:

Please describe any other symptoms associated with the reason for today's visit:

Have any images been taken for this problem? Y / N Where were they done?

What type of images? (x-ray, MRI, etc): Approximate date of imaging:

Has anyone else treated you for this condition? Y / N

If yes, where? (ED, urgent care, training room, another doctor, chiropractor, etc):

PAST MEDICAL HISTORY

Do you have allergies to any of the following?

Medications: Y / N Please list:

Medical products: Y / N Please list:

Foods: Y / N Please list:

**CURRENT MEDICATION (S) YOU ARE TAKING:**

NAME	DOSAGE	FREQUENCY	REASON FOR MEDICATION

<b>REVIEW OF SYSTEMS:</b> Are you <b>currently</b> experiencing any of the following?					
Fever, Chills, Night Sweats	Yes No	Skin Rashes, sores, or Lacerations	Yes No	Skin Spots or Birthmarks	Yes No
Weight Loss	Yes No	Any Additional Muscle Pain	Yes No	Numbness or Tingling	Yes No
Eye Pain	Yes No	Joint Pain	Yes No	Heart Burn/Reflux	Yes No
Chest Pain	Yes No	Headaches or Dizziness	Yes No	Difficulty Sleeping	Yes No
Abdominal Pain	Yes No	Depressed	Yes No	Bowel or Bladder Accidents	Yes No
Burning/Frequency/Difficulty with Urination	Yes No	Easy bruising or bleeding	Yes No		

**FEMALES ONLY:** Age of first period: \_\_\_\_\_

Do you have a period every month? Y / N      If no, please explain: \_\_\_\_\_

**SOCIAL HISTORY:**

Do you attend school? Y / N      If yes, what grade level? \_\_\_\_\_

What sports do you play? \_\_\_\_\_

What school/team(s) do you play for? \_\_\_\_\_

Name of Coach/trainer \_\_\_\_\_

May we discuss today's care with your coach or trainer? Y / N

Are you happy at your current weight? Y / N      If no, what is your ideal weight? \_\_\_\_\_

Do you follow any special diet?      Please explain \_\_\_\_\_

Do you take any supplements to enhance sports performance or weight management? Y / N

Please list \_\_\_\_\_

Does the patient use or have a history of using any of the following?

Alcohol      Y / N      How much? \_\_\_\_\_      How often? \_\_\_\_\_

Chewing tobacco      Y / N      How much? \_\_\_\_\_      How often? \_\_\_\_\_

Cigarettes?      Y / N      Packs per day? \_\_\_\_\_      For how long? \_\_\_\_\_

DOES THE PATIENT HAVE ANY PERSONAL HISTORY OF THE FOLLOWING? PLEASE INDICATE					
Asthma	Yes No	Lung Disease	Yes No	Diagnosed with Cancer	Yes No
Blood Disorder	Yes No	Previous Fractures	Yes No	Kidney Disease	Yes No
Heart defect, Pacemaker/valves	Yes No	Brain or Spinal Cord	Yes No	Scoliosis	Yes No
Cochlear Implant	Yes No	Bone Disorder	Yes No	Developmental delay	Yes No
Diabetes	Yes No	Cardiac Arrhythmias	Yes No	Heart Disease	Yes No

If yes to any above, please describe \_\_\_\_\_

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Any family history of above illness(es)? Y / N

If yes, please indicate illness and which family member has the condition:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any previous surgeries? Y / N

If yes, please indicate what type of surgery, hospital, and year it was performed:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please provide any additional information which may be helpful to know about today's visit and your medical care: \_\_\_\_\_

\_\_\_\_\_

PHYSICIAN NOTES: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
PERSON COMPLETING THIS FORM

\_\_\_\_\_  
RELATIONSHIP TO PATIENT

\_\_\_\_\_  
PHYSICIAN/PRESCRIBER SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
TIME