



### 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