Date_____

Women's Sports Medicine Center

Confidential Medical History

Name _____ Age _____ Birthdate_____

Home # _____ Work # _____

Occupation_____ Referred by _____

○ Right Handed ○ Left Handed

Chief Complaint _____

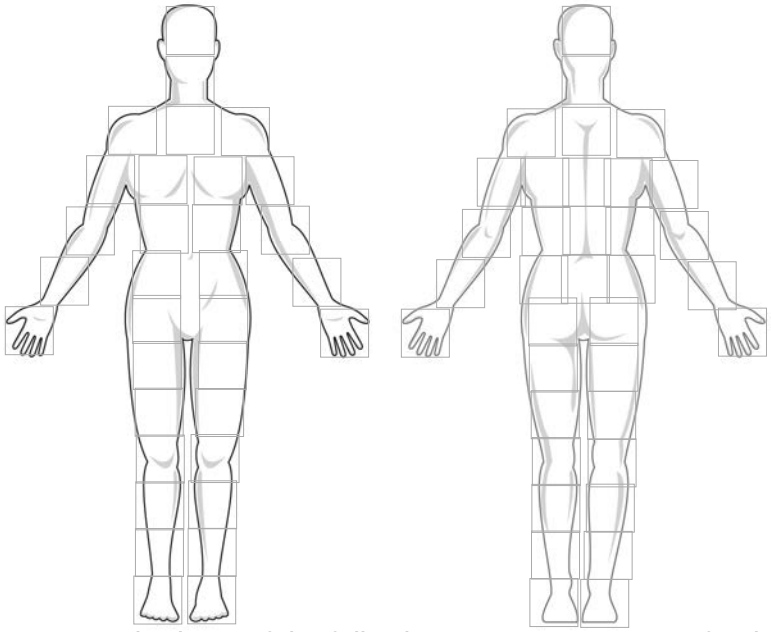
Date of injury or onset of symptoms _____

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**	**Treatments** (If so, describe whether they helped.)	
☐ X-RAY	_____	☐ MEDICATIONS	_____
☐ MRI	_____	☐ INJECTIONS	_____
☐ CT SCAN	_____	☐ SURGERY	_____
☐ MYELOGRAM	_____	☐ PHYSICAL THERAPY	_____
☐ BONE SCAN	_____	☐ OTHER TESTS AND TREATMENTS	_____
			_____

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
			■	■	Shortness of breath or wheezing
■	■	Kidney disease or kidney stones	■	■	Frequent cough
■	■	Vision problems/eye disease	■	■	Chest pain
■	■	Eating disorder	■	■	Heart murmur
■	■	Nose/throat problem	■	■	Irregular heart beat
■	■	Hearing problems/ear disease	■	■	Heart disease
■	■	Stomach pain or heartburn	■	■	Swollen legs or feet

Social History

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

Physical Activity

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? (select one)

◉ 10-12 ◉ 7-9 ◉ 5-6 ◉ 1-4 ◉ none

Number of Pregnancies: ◉ 0 ◉ 1 ◉ 2 ◉ 3 ◉ 4 or more

Would you like us to send copies of your notes to your primary care physician? ◉ Y ◉ N

Primary Care Physician _____

Mailing Address _____

Phone # _____ Fax # _____

Are there any specific questions that you would like to discuss today?

1. _____
2. _____
3. _____

Signed by Patient: _____ ***Date:*** _____

Office only: *Reviewed by:* _____ *Date:*_____

Print Form