SLUCare Physician Group

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)

Disease	Family Member	Disease	Family Member
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