

SHORE SPORTS MEDICINE

MEDICAL HISTORY FORM

Name: _____ Date: _____

DOB: _____ AGE: _____

Current Medical Problem/Past Medical History: _____

Current Prescription Medications: (Include Dosage): _____

List over-the-counter medications, vitamins, food supplements: _____

Allergies: _____

List any significant family history (heart disease, cancer, etc.) _____

List past surgeries (Please include date and Surgeon): _____

Describe any hospitalizations/illnesses not noted above (include year & hospital):

Do/Did You Exercise? _____ How Much? _____ hrs/wk #of Years: _____ Year you Stopped? _____

Do/Did You Smoke? _____ How Much? _____ Packs/Day _____ #of Years: _____ Year you Stopped? _____

Do/Did You Drink Alcohol? _____ How Much? _____ Drinks/wk _____ #of Years: _____ Year you Stopped? _____

Previous or current problem with alcohol? _____

Have you had:

- | | | | |
|--|--------------------------------------|--|--|
| <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Migraines | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mono |
| <input type="checkbox"/> Ulcer | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Drug Addition |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> STD's | <input type="checkbox"/> Seizures | <input type="checkbox"/> Memory Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Shingles | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Depression | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Hearing Trouble | <input type="checkbox"/> Vision Trouble |
| <input type="checkbox"/> Other | _____ | _____ | _____ |

Are you currently employed? _____ Occupation? _____ How long? _____

Patient Signature

Date