ALTA VIEW SPORTS MEDICINE

PATIENT INFORMATION

Patient Name _____ Date _____

Referring or Primary Care Doctor _____ Phone _____

Are you: ❑ right handed ❑ left handed Your Age _____

HISTORY OF CURRENT PROBLEM

CHIEF COMPLAINT – What is your reason for today's visit? Please describe.

IF INJURED – Describe how you were injured. Date of Injury _____ ❑ At Work?

IF NOT INJURED – Approximately when did your symptoms first appear?

HEALTH HABITS

HEALTH HABITS Check (✓) which substances you use and describe how much you use.

❑ Caffeine _____ ❑ Drugs _____

❑ Tobacco _____ ❑ Other _____

❑ Vitamins or Supplements _____

OCCUPATIONAL

Your Occupation _____

❑ Average Lifting _____ Yes ❑ No ❑ Bending

❑ Maximum Lifting _____ Yes ❑ No ❑ Squatting

Yes ❑ No ❑ Overhead Work Yes ❑ No ❑ Kneeling

MEDICATIONS ❑ NONE

List prescription and non-prescription medications you are currently taking.

Medication _____ Dose per pill _____ Frequency _____

Medication _____ Dose per pill _____ Frequency _____

Medication _____ Dose per pill _____ Frequency _____

Medication _____ Dose per pill _____ Frequency _____

ALLERGIES ❑ NONE

List any allergies and your reaction to medication and/or other substances.

_____ _____

_____ _____

_____ _____

HEALTH HISTORY All information is strictly confidential.

Please check (✓) any of the following that apply and describe at the bottom

- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Disorders
- ❑ Blood Clots
- ❑ Bowel changes
- ❑ Bruise easily
- ❑ Cancer
- ❑ Change in Moles
- ❑ Chemical Dependency
- ❑ Chest Pain
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Herpes
- ❑ High Cholesterol
- ❑ High/Low blood pressure
- ❑ HIV Positive
- ❑ Hives
- ❑ Irregular/Rapid heart beat
- ❑ Itching/Rash
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Migraine Headaches
- ❑ Multiple Sclerosis
- ❑ Pacemaker
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate Problem
- ❑ Rheumatic Fever
- ❑ Scars
- ❑ Sore that won't heal
- ❑ Stomach Acid Reflux
- ❑ Stroke
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Varicose veins
- ❑ Venereal Disease

PAIN, WEAKNESS, NUMBNESS IN:

- ❑ Arm
- ❑ Back
- ❑ Feet
- ❑ Hands
- ❑ Hips
- ❑ Legs
- ❑ Neck
- ❑ Shoulders

PLEASE EXPLAIN ANY ITEMS THAT ARE CHECKED OFF, UNLESS SELF EXPLANITORY _____

SURGICAL HISTORY ❑ NONE

PROCEDURE	YEAR	FACILITY
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe any adverse reactions to past surgeries _____

FOR OFFICE USE ONLY, PATIENT, PLEASE LEAVE BLANK

Weight _____ Height _____ Blood Pressure _____ Pulse _____

SIGNATURES

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ **Date** _____

Reviewed By _____ **Date** _____