GRANGER MEDICAL CLINIC

Alta View Sports Medicine

PATIENT INFORMATION

Patient Name:_____ Date: _____

Primary Care Doctor: _____ Phone: _____

Are you: ☐ Right-handed ☐ Left-handed Sex: _____ Your Age: _____

HISTORY OF CURRENT PROBLEM

Chief Complaint - What is the reason for today's visit? Please Describe.

_____

_____

_____

If Injured - Describe briefly 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: How much_____ Yrs_____

☐ Alcohol: How much_____ Yrs_____

☐ Marijuana: How much _____ Yrs_____

Occupational

Your Occupation _____

☐ Drugs: How much_____ Yrs_____

☐ Tobacco: How much _____ Yrs_____

☐ Vitamins or Supplements: How much _____ Yrs_____

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 medicine and/or other substances

_____ _____

_____ _____

_____ _____

OVER

MEDICAL 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
- ☐ Cancer
- ☐ Change in moles
- ☐ Chest pain
- ☐ Diabetes ☐Type 1 ☐Type 2
- ☐ Emphysema
- ☐ Pulmonary embolism
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart disease
- ☐ Hepatitis
- ☐ High cholesterol
- ☐ High/low blood pressure
- ☐ HIV positive
- ☐ Hives
- ☐ Irregular/rapid heartbeat
- ☐ 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
- ☐ Ulcers
- ☐ Varicose veins
- ☐ Other _____

Please explain any items that are marked unless self explanatory _____

SURGICAL HISTORY

NONE

Procedure	Year	Facility

Descibe 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 any members of his/her staff responsible for my errors or ommisions that I may have made in the completion of this form.

Signature _____ Date _____

Reviewed by _____ Date _____