



Sports Medicine & Orthopaedic Center

	Today's Date:
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HEALTH HISTORY QUESTIONNAIRE

All questions are confidential and will become part of your medical record.

Name <i>(Last, First, M.I.):</i>	<input type="checkbox"/> M	<input type="checkbox"/> F	DOB:
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Marital status:	<input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
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Referring Doctor:

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____

Fax: _____

Females Only: Is there any possibility you are pregnant? Yes No

PERSONAL HEALTH HISTORY

Reason for seeing Doctor today: _____ Area injured _____

Date of Injury _____ Any Treatment to Date? MRI Ct Scan X-Ray Physical Therapy Surgery

How Did Injury Occur? _____

List any medical problems that you receive treatment or take medicine for:

Surgeries

Year	Procedure Performed	Surgeon



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List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers				
Name the Drug	Strength	Frequency Taken		
Allergies to medications		Reaction You Had		
Social History				
Alcohol	Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	How many drinks per week?			
Tobacco	Do you use tobacco?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day	<input type="checkbox"/> Cigars - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit		
Drugs	Do you currently use recreational or street drugs?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Personal Safety	Do you live alone?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have stairs to climb?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have vision or hearing loss?			<input type="checkbox"/> Yes <input type="checkbox"/> No
FAMILY HEALTH HISTORY				
	AGE	SIGNIFICANT HEALTH PROBLEMS		
Father				
Mother				



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OTHER PROBLEMS

Please explain or list any problems in the following areas

Skin: Yes No Explain:

Neurological Disorders: Yes No Explain:

Chest/Heart: Yes No Explain:

Lungs Yes No Explain:

Head/Neck: Yes No Explain:

Thyroid/Diabetes: Yes No Explain:

Back: Yes No Explain:

Ears/Eyes: Yes No Explain:

Nose: Yes No Explain:

Throat: Yes No Explain:

Intestinal/Bowel: Yes No Explain:

Kidney/Liver Problems: Yes No Explain:

Bladder/prostate: Yes No Explain:

Cancer: Yes No Explain:

Musculoskeletal/Arthritis: Yes No Explain:

Lyme Disease: Yes No Explain:

Circulation: Yes No Explain:

Recent changes in Weight: Yes No Explain:



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Bleeding Disorders: Yes No Explain:

Blood clots/phlebitis: Yes No Explain:

Other: Yes No Explain: