AZ SPORTS MEDICINE

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Patient Name: _____DOB_____Height_____Weight_____
What are you seeing the doctor for today: _____ Affected side: Left Right
Date of injury or onset of problem: _____ Dominant Hand: Left Right
Work Related? □Yes □ No Auto Accident? □ Yes □ No Attorney Involved? □ Yes □ No
Have you had x-rays taken? □Yes □ No If yes, where? _____
Have you had an MRI? □Yes □ No If yes, where? _____
Pharmacy: _____ Pharmacy Cross streets or address: _____
Pharmacy Phone Number: _____
Drug Allergies: □ Yes □ No Please list drug and reaction_____

Daily Medications: (please include pain meds, herbs, vitamins & OTC)

Name	Dosage/Strength	Times/day

Past Surgical History (list type and date)

_____
_____
_____

Past Medical/Hospital History (Illness/Conditions):

_____
_____
_____

Do you smoke? □ Yes □ No Packs per day:_____
For how many years?_____
Do you exercise? □ Yes □ No How Often?_____
What type? (Running, biking, etc.) _____
Do you drink alcohol? □ Yes □ No
If yes, average consumption a week?_____
What is your occupation?_____

Do you now or have you ever had:

Anemia…….…….....…..….	Yes	No
Diabetes……..…	Yes	No
Cancer/Type……..….	Yes	No
Kidney Trouble……..	Yes	No
Bladder Issues……	Yes	No
High Blood Pressure……..	Yes	No
Heart Trouble…….	Yes	No
High Cholesterol……..…	Yes	No
Asthma……	Yes	No
Neurological Disorder/Seizures……...	Yes	No
Depression……..	Yes	No
Stroke……...	Yes	No
Thyroid Disorder……	Yes	No
Ulcer/Stomach Problems……	Yes	No
Hepatitis (Type)……	Yes	No
Arthritis……..	Yes	No
Gout……	Yes	No
Phlebitis/Blood Clots…….	Yes	No
AIDS/HIV……...	Yes	No
Substance Abuse…….	Yes	No
Fibromyalgia…….	Yes	No
Sleep Apnea…….	Yes	No

Family History:
Please list any major medical conditions & if they are deceased or alive:
Father:_____
_____
_____
Mother:_____
_____
_____
Siblings:_____
_____
_____

Is there any possibility you could be pregnant? □ Yes □ No

Has any blood relative younger than 50 ever had unusual bleeding tendencies? □ Yes □ No

If yes, who and what is their age:_____

Have you or any blood relative, younger than 50, ever had a serious reaction to anesthesia? □ Yes □ No

If yes, who and what is their age?_____

The above information is, to the best of my knowledge, a true statement of my current condition.

Patient Signature:_____Date:_____