ADVANCED CENTER FOR SPORTS & MUSCULOSKELETAL MEDICINE

Health History Form

Patient Name_____**Date**_____
Referred by □**MD/DO**_____ □**Self/Friend**_____□**Other**_____
Date of birth_____ **Weight**_____ **Height**_____ **Age**_____ **Sex** □ **M** □ **F**

REASON FOR COMING TO THE DOCTOR

1. **Area of the body/complaint**_____
2. **How long has this condition been going on for?**_____
3. **Was there something that happened to start this problem?**_____
4. **What are the symptoms that you are experiencing?**_____
5. **How bad is the pain/are the symptoms (1-10)?**_____
6. **What is the pattern of the pain/symptoms (constant, intermittent, etc)?**_____
7. **What make the symptoms better or worse (postiion, medicine, procedure, etc)?**_____
8. **Any radiation of symptoms or is it localized?**_____
9. **Any other associated symptoms (numbness, fever, etc)?**_____
10. **Is this a first time occurrence? If not, what happened in the past?**_____
11. **Have you seen a physician for this problem in the past?**_____
12. **What activities/sports do you participate in?**_____

CURRENT SYMPTOMS – Review of Systems (check all that apply) □**None**

□**Fever/chills/weight loss**	□**Headaches/visual or hearing problems**	□**Chest pain**
□**Breathing problems**	□**Stomach/intestinal problems**	□**Urinary or kidney problems**
□**Easy bruising/bleeding**	□**Neurological: numbness & tingling**	□**Psychological: anxiety or depression**
□**Skin problems**	□ **Bone or joint pain**	□ **Muscle/tendon problems**

□**Other**_____

MEDICAL HISTORY □**None**
List_____
_____

SURGICAL HISTORY □**None**
List_____
_____

CURRENT MEDICATIONS (Prescription, over the counter medications, supplements, herbs, & vitamins) □**None**
List_____
_____

ALLERGIES (Food, Medication, Seasonal) □**None**
List_____
_____

FAMILY MEDICAL HISTORY □**None**
ONLY Grandparents, Parents, Siblings, & Children
List_____
_____

SOCIAL HISTORY
□**Occupation** _____ □**School**_____
Marital Status □ **S** □ **M** □ **D** □ **W**
Smoking □ **No** □ **Former: How much, for how long?** _____ □**Yes: how many packs/day?** _____
Alcohol □ **No** □ **Yes: how much?**_____
Other drug use □ **No** □ **Yes: describe** _____

_____ _____
Patient signature **Provider signature**