SportsMED
Orthopaedic Surgery & Spine Center

Name ______________________ Date of Birth: ______________ SS#: ________________

PATIENT MEDICAL HISTORY (CHECK APPLICABLE CONDITIONS)

Family Physician: ______________________________ Date of last physical: ________________
Any abnormal findings? If yes, briefly describe: ________________________________
Do you smoke? ☐ Y ☐ N Do you drink? ☐ Y ☐ N If so, how many drinks per day? ____________
Do you have any cultural concerns? If so, please state: ________________________________

Eye/Ear Problems			Nose/Throat/Neck			Cardiovascular Problems		
Glaucoma/Cataracts	☐ Y	☐ N	Hoarseness/Changes in Voice	☐ Y	☐ N	Chest Pains/Irregular Heartbeats	☐ Y	☐ N
Glasses/Contact Lenses	☐ Y	☐ N	Nose Bleed	☐ Y	☐ N	Low or High Blood Pressure	☐ Y	☐ N
Loss of Hearing/Hearing Aids	☐ Y	☐ N	Thyroid Problems	☐ Y	☐ N	Heart Attack	☐ Y	☐ N
Respiratory Problems			**Gastrointestinal Problems**			**Urinary Problems**		
Asthma/Wheezing	☐ Y	☐ N	Stomach Ulcers	☐ Y	☐ N	Infection	☐ Y	☐ N
Shortness of Breath	☐ Y	☐ N	Gallbladder trouble/Hiatal Hernia	☐ Y	☐ N	Prostate	☐ Y	☐ N
Painful Breathing	☐ Y	☐ N	Pancreatitis/Liver trouble	☐ Y	☐ N	Bladder	☐ Y	☐ N
Coughing up Blood	☐ Y	☐ N	Blood in Stool	☐ Y	☐ N	**Skin Afflictions**		
Immune Disorders			**Neurological Problems**			Psoriasis	☐ Y	☐ N
AIDS/HIV	☐ Y	☐ N	Headaches	☐ Y	☐ N	Skin Cancer	☐ Y	☐ N
Metabolic Problems			Fainting/Blackouts	☐ Y	☐ N	Infections	☐ Y	☐ N
Diabetes	☐ Y	☐ N	Seizures/Epilepsy	☐ Y	☐ N	**Bleeding Disorders**		
Low Blood Sugar	☐ Y	☐ N	Strokes/Paralysis	☐ Y	☐ N	Anemia	☐ Y	☐ N
Gout	☐ Y	☐ N				Bleeding Problems	☐ Y	☐ N

Have you been diagnosed with cancer? ☐ Y ☐ N Do you have arthritis? ☐ Y ☐ N

Do you have a family history of:

Diabetes	☐ Y	☐ N
Cancer	☐ Y	☐ N
Heart Disease	☐ Y	☐ N
High Blood Pressure	☐ Y	☐ N
Strokes	☐ Y	☐ N
Tuberculosis	☐ Y	☐ N

Female History:

Are you pregnant?	☐ Y	☐ N
Are you on the pill?	☐ Y	☐ N
Postmenopausal?	☐ Y	☐ N

If yes, number of years: ____________

PAST SURGICAL HISTORY:

Date	Procedure

PLEASE LIST CURRENT MEDICATIONS

Medication	Dosage	Last Taken

MEDICATION ALLERGIES

Latex Allergy ☐ Y ☐ N

If you need more room, please include an additional sheet

TO BE COMPLETED BY PHYSICIAN ONLY

General: WD WN
Psychological: Awake Alert
Heart: WNL Other ______________
Lung: Clear Other ______________
Abdomen: WNL Other ______________
Orthopaedic: See Progress Notes

Physician Signature: ______________________
Date: ______________
Time: ______________