PRINCETON SPORTS & FAMILY MEDICINE

Medical History
New Patient and Physical Form

Name: _____ D.O.B. _____

Height: _____ Weight: _____ Sex: _____ Occupation: _____

Pharmacy: _____Location: _____

Reason you are here today:

_____ New Patient to Meet New Primary Care Physician

Initial here *Discuss medical history, chronic medical conditions, review medications and evaluate a new problem.*

_____ Annual Physical with Primary Care Physician

Initial here *Evaluation of any new or chronic medical problems may require a co-pay, deductible or co-insurance.*

_____ New Patient to Meet New Sports Medicine Physician - Discuss Injury & History

Initial here *Evaluation of any general medical conditions will require an appointment with our Primary Care Physicians.*

Allergies/Intolerances (Food, Medications, Environmental). Please list allergen and reaction.

_____ _____

_____ _____

Past Surgeries and Dates

_____ _____

_____ _____

OB/GYN History

Pregnancies_____ Live Births _____ Miscarriages_____ Abortions _____ C-Sections _____

Specialists and Other Medical Personnel Involved in Care

_____ _____

_____ _____

_____ _____

_____ _____

Chronic Medical Conditions **Current Medications and Doses**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

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Please check/circle if you CURRENTLY have any of the following:
___Fever ___Chills ___Weight gain ___Weight loss ___Ear pain ___Sore throat ___Nasal congestion
___Fatigue ___Heat intolerance ___Cold intolerance ___Cough ___Shortness of breath ___Wheezing
___Chest pain ___Palpitations ___Leg swelling ___Nausea ___Vomiting ___Diarrhea ___Constipation
___Abdominal pain ___Painful urination ___Frequent urination ___Blood in urine ___Rash ___Acne
___Headache ___Dizziness ___Numbness___Joint pain ___Joint swelling ___Weakness ___Balance difficulty

Social History
Marital Status: ___Single ___Married ___Divorced ___Widowed ___Partnership
Children: ___ Sons ___Daughters
Do you drink alcohol? ___Yes ___No How often? _____ # drinks per day _____
Do you smoke? ___Yes ___No ___In the past # per day _____ # Years _____ Type _____
Have you ever used illegal drugs? ___Yes ___No If yes, did you use IV drugs?
Are you sexually active? ___Yes ___No If yes, ___Men ___Women ___Both
Have you ever received a blood transfusion or blood products? ___Yes ___No
If yes, when and why? _____

Habits
Do you exercise? ___Yes ___No How often? _____ Type of exercise _____
Do you drink caffeine? ___Yes ___No Cups per day _____ Type of caffeine_____
What kind of diet do you follow? ___Unrestricted ___Low salt ___Low fat ___Vegetarian ___Vegan
___Gluten free ___Lactose free
How are you sleeping? ___No problem ___Difficulty falling asleep ___Difficulty staying asleep
___Snoring ___Daytime drowsiness

Family Medical History

	Deceased or Living	Age(s)
Mother		
Father		
Brother(s)		
Sister(s)		
Spouse		
Children		

Has any blood relative had any of the following? (Please check and give relationship, and age of onset)
Stroke _____ Epilepsy_____ Heart Attack _____ Nervous Breakdown _____
Cancer (type) _____ Diabetes _____ Stomach ulcer _____ Migraines _____ Arthritis _____
Hypertension _____ Asthma _____ Kidney Disease _____ Glaucoma _____
Bleeding disorder _____ Mental illness _____ Osteoporosis _____ Thyroid disease _____
Pulmonary disease _____ Neurological disease _____ Other _____

Preventative Care and Immunization History (List date of your last test/screening/vaccination)

Meningococcal Vaccine:	Bone Density Screening:
Shingles Vaccine:	Pap Smear:
Tetanus Vaccine:	Dental Exam:
Pneumonia Vaccine:	Physical Exam:
HPV Vaccine:	Eye Exam:
Flu Vaccine:	Rectal/Prostate Exam:
Hepatitis A Vaccine:	Endoscopy:
Hepatitis B Vaccine:	Colonoscopy:
Tuberculosis (PPD) Screening:	EKG: