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: